S. HRG. 107–241

MEDICARE GOVERNANCE: PERSPECTIVES ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (FORMERLY HCFA)

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

JUNE 19, 2001

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

75–560—PDF WASHINGTON : 2001

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MEDICARE GOVERNANCE: PERSPECTIVES ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (FORMERLY HCFA)

TUESDAY, JUNE 19, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Breaux, Conrad, Kerry, Lincoln, Grassley, Hatch, Snowe, and Kyl.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Good morning, everybody. I welcome you all today, particularly Secretary Thompson, Mr. Scully, witnesses.

We are shifting gears a little bit today, moving from tax legislation to prescription drugs and Medicare issues. We are very honored today to have a different part of the executive branch here. Secretary Thompson and Mr. Scully, we very much appreciate your coming today.

Essentially, we are trying to determine jointly just what we can do to help seniors in our country, providers, and everyone affected feel even better about Medicare, about prescription drugs, and about the organization of HCFA, now CMS. As public servants we are charged with the task of trying to help people better understand and feel better about the agency and ensure it is working a lot better.

I need not remind you, Mr. Secretary, that virtually every member of Congress has at one time or another said we should reform Medicare, we should reform HCFA, and Medicare should provide prescription drug benefits for seniors. The President has also said this.

In fact, many of us have been making some of those same statements for decades. I might add that this committee had 15 hearings on prescription drug benefits in the last Congress. We were unable to pass legislation, but I think the number of hearings indicates the level of interest in the subject.

I think I speak for all of the committee when I say that enough time has passed. It is time for us to start acting. For that reason, both Senator Grassley and I agree that we should that we should

do our level best to report a bill out by the end of July, that is, before the August recess. It is a bit ambitious.

Secretary THOMPSON. Congratulations, Senator.

The CHAIRMAN. Well, thank you, Mr. Secretary. It is a bit ambitious but we are going to do our level best to accomplish that in that time schedule.

Some people will say that we have to do probably even more to cover benefits than this committee might be willing to do at this point. Some say we should not worry so much about benefits, but rather reform Medicare. It is my judgment, Mr. Secretary, that we should try to do both. That is, while we are providing benefits, we also should seriously undertake efforts to "reform" the program.

Now, reform is in the eyes of the beholder, naturally. But I think all of us know that we need to inject some competition into Medicare. We definitely need more competition and we need to give seniors some choices. More than anything else, we ought to make sure that the program runs better.

This brings me to the subject of the hearing. I know that you, Mr. Secretary, have given HCFA a new name. I know that you were considering another name and, for various reasons, thought that was not entirely appropriate. But giving the agency the new name, Centers for Medicare and Medicaid Services, I think, helps. It is a psychological signal and a start to getting something done.

Secretary THOMPSON. It really is.

The CHAIRMAN. I also know the agency is under-funded. Over the years, Congress has been asking HCFA to do more and more without corresponding increases in resources. This committee knows that.

I know some of the problems you are facing with the Appropriations Committees. I would like to explore with you, Mr. Secretary, ways that we can work with you and the Appropriations Committee to address that.

I think the problems really come down to just a few main ones. First, and probably the most important, is how the agency communicates with people and with organizations affected by its decisions.

Time and time again, I hear complaints from both beneficiaries and providers, and I know you do, too. They complain about customer service, about confusing rules and regulations.

Another big problem, is personnel. I do not mean to imply that HCFA, CMS, lacks dedicated employees; you certainly have plenty. Rather, I think the agency lacks some of the necessary skills.

For example, few of its employees have experience in the private sector. They may not have experience overseeing private health plan options, which they are now asked to do. Having spent some time in the private sector as a practicing attorney, I know that it does make a big difference to see both sides.

I am also concerned about information technology. At a time when we have become so reliant on technology, I hear again and again that HCFA's technology is outdated and is inadequate. Again, this is a resource issue.

I am also interested in hearing more about HCFA's ability to oversee its contractors. I am glad to hear that the administration is focusing on making HCFA, or CMS, more responsive. There are a lot of new, provocative ideas on selecting contractors, nomina-

tions, et cetera. I think those ideas are good ones that need to be pursued.

I am interested in hearing, Mr. Secretary, what changes you plan to make on your own. I am also interested in hearing from you what changes you think that Congress must make, either in the context of prescription drugs or in the context of Medicare reform. So, with that I welcome you to the hearing.

I would like, now, to turn to my good friend and colleague, Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. You were reflecting on turning from taxes to Medicare. We thought taxes were tough. Medicare will be very tough. Also, whatever words you use about reform of Medicare, or improvement of Medicare, restructuring, what it all adds up to—and I am not disagreeing with anything that the Chairman said—is that Medicare should reflect the practice of medicine today.

Quite frankly, you cannot have a Medicare program reflecting the practice of medicine today if it does not include an emphasis upon prescription drugs. Obviously, the reason for the emphasis upon prescription drugs is prescription drug programs now are one way of keeping people out of hospitals. When Medicare was structured in the first place, the practice of medicine was to put people into hospitals. So, the two very much go together.

I thank Chairman Baucus for calling this hearing because I think it is always important that our committee keep up on what is going on through bureaucratic decision making, administrative decision making, as well as what we do here in the Congress as a whole.

In fact, along that line, when we talk about changes of Medicare that reflect the practice of medicine, obviously all those changes do not have to be done by legislative action.

In fact, I have heard from people within the administration that perhaps even more than a majority of the changes that can be made can be done through administrative action. So, obviously we are not only here to keep up on what you are doing. We encourage you to do what you are up to.

So, we look at today as an opportunity to have a progress report from the Secretary of HHS, Governor Thompson and his team to strengthen the administration of Medicare and Medicaid.

These programs obviously are critically important to our constituents and we can, and should, make them work better. I know that is what you are about doing, Secretary Thompson.

In my view, right now it is surely too soon to expect major results from a new team. You have been on the job, Secretary Thompson, for just 5 months; the person beside you, highly-qualified Mr. Scully, has been there less than 1 month.

So, I assure you that this hearing is by no means a final exam. As you know well, there is much more to do. I notice that the reforms that you announced on Thursday, you yourself referred to them as first steps. So, you clearly recognize that there are many more steps ahead, and maybe even some follow-up hearings for our having an opportunity to discuss those changes with you.

I think I should make clear that I have been impressed by your initial efforts, Secretary Thompson, and those of Administrator Scully. The President chose you to do these jobs because you are well-known as can-do reformers who can shake things up and get things done. Obviously, this is a breath of fresh air.

Today, I do want to hear more details on changes recently announced for the agency now known as the Centers for Medicare and Medicaid Services. I am particularly interested in learning more about your ideas for the Medicare education campaign because I have long felt that there is much more than can be done to educate beneficiaries about the often confusing Medicare programs. Now that you have taken these first steps, I also want to hear your ideas about what the next steps might be.

I am also interested in the CMMS's ability to administer major program improvements that I hope that we will enact this year, including the prescription drug benefit.

I look forward to working closely with you to continue to improve efficiency and responsiveness of the newly-named agency, Centers for Medicare and Medicaid Services.

Thank you.

The CHAIRMAN. Thank you very much, Senator Grassley.

Now, for a brief statement from my good friend and colleague, Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman. Thank you for inviting the Secretary and Administrator to be the first witnesses on this very important subject. It seems that the more difficult the problem, the more we talk about it or the more we appoint commissions to help us solve the problems.

Of course, Medicare is a prime example of that. Last year, we had 17 days of hearings on Medicare reform and we did not produce a single sentence on reform. I think the problem is immense, but it is not insolvable.

Medicare, in 1965, was a wonderful program. But, since 1965, we have basically just added to it. We have never really reformed it, we have just added more things that you have to do. Today, we have 133,000 pages of regulations, which I am sure you have read each and every one of those pages and understand it fully.

Secretary THOMPSON. Twice.

Senator BREAUX. But we have a program that is a 1965 program that we are trying to make work in the 21st century, and you just cannot do that. There are some things you can do internally. I applaud you for doing it.

Changing the name is the beginning, but there is a lot more that needs to be done in terms of fundamentally modernizing it and restructuring the program. Hopefully, we can hear some of these suggestions and ideas today.

It is not enough for us to just add more benefits, because if we do that without fundamentally reforming the system, we will make a serious mistake.

This committee cannot continue to micromanage this program. We cannot continue to sit in this little back room and figure out

what the proper reimbursement rate is for rural ambulance services, which we do, among other things, on a regular basis.

So we have to think big picture, and hopefully your earlier statements, Mr. Secretary, have indicated that that is exactly what you want to do. We applaud you for that.

The CHAIRMAN. Thank you, Senator.

Senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here, and Tom Scully as well.

I also applaud your efforts, and I like the name change. I think it communicates better exactly what the role and function is. So, I think it is a useful thing because it helps people understand precisely what is going on.

Two things I wanted to mention just briefly, Mr. Chairman, if I could. One, is rural health care. We have a very substantial difference between the reimbursement for Medicare for urban facilities and rural facilities.

Even among rural facilities there are very substantial differences. If you go to Mercy Hospital in Devil's Lake, North Dakota and you look at Mercy Hospital in New York, you look at a heart attack, the hospital in New York gets twice as much reimbursement from Medicare to deal with that illness. The same is true for illness after illness. This is a gap that really needs to be closed.

I have introduced legislation, along with a bipartisan group in the Senate and a bipartisan group in the House, to address some of these problems, including the base payment problem and the low-volume adjustment payment.

The smallest hospitals are the ones that are really hemorrhaging. I have got 44 hospitals in my State, 12 of them are in danger of closing. We all know that those small hospitals have negative margins on their Medicare patients, according to the studies that have been done, and that needs to be addressed.

The final point I wanted to make is on Medicare payment delays. We have had, in May, hospitals come to us and indicate that Medicare was as much as 3 months in arrears on payments. When you have got hospitals that are already in serious trouble, having Medicare be three months in arrears——

Secretary THOMPSON. It is not acceptable.

Senator CONRAD [continuing]. Is a very serious matter.

I sent a letter to you on May 16, 2001 on this subject, and the arrearages were brought up to date. I want to thank you for that. But I do want to focus on the issue because something is wrong and requires your attention.

I thank the Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Kerry, any comments you want to make?

OPENING STATEMENT OF HON. JOHN F. KERRY, A U.S. SENATOR FROM MASSACHUSETTS

Senator KERRY. Mr. Chairman, I guess technically not a member of the committee.

The CHAIRMAN. Well, you are here in spirit.

Senator KERRY. I hope I am here in more than spirit.

The CHAIRMAN. You will be soon. Body, spirit, and officially a member.

Senator KERRY. Body, spirit, and mind.

Well, thank you for allowing me the privilege of speaking before we pass a resolution. I appreciate that.

Just very briefly. In the years that I have been here now, and it is a long time but not as long as the two gentlemen at the head of the dais, a certain frustration builds up over time.

I know, Mr. Secretary, you have expressed that frustration. We pass a law, we think we are going to fix something, and then the interminable bureaucracy just interprets it in the most wild ways and we wind up with counterproductive efforts and not accomplishing our goals.

Nowhere is this more true, it seems, than in the health care system, and particularly in the predecessor entity HCFA, which has become one of the most reviled bureaucracies in American government today.

Obviously a lot of it is cliche, but we need desperately to try to work through this. I know you want to do that, and we want to do that with you here.

Senator Murkowski and I have introduced the Medicare Regulatory and Education Fairness Act in an effort to try to at least deal with one tiny component of it. That is part of the problem. We are always doing these little Band-Aid pieces, a little bit here, a little bit there.

My hope is that we will be able to do that in the context of this new user-friendly, service-oriented, well-named entity. But obviously—and you know this better than anybody—changing the name is not going to do anything unless we change the practices.

When Senator Murkowski and I announced this, we had a table—I think it was this table right here—just completely filled with all of the books, regulations, paperwork, and things people have to do. It is absurd.

Moreover, some of the practices, as they then get interpreted, are crazy. The auditing process. The extrapolation method for audits where you take one $450 human error, non-intentional error, and translate it into a $37,000 or $47,000 fine and put people out of business almost. I mean, it is just a sort of nonsense approach that I think is driving everybody crazy.

But the most important piece as we look at the Medicare reform effort in the larger context, is I met the other day with all of the leading hospitals up in Boston. I know that you know, Mr. Secretary, they are great hospitals. They are extraordinary institutions.

We have people who come from all over the world for medical care here. We have driven the technology curve in the provision of medicine in this country. People will belly-ache when there is

change in the air. Indeed, probably, we had too many hospitals over a period of time.

But as some people have looked at the problem of rural America, which Senator Conrad just talked to, or as they have looked at the problem in other parts of the country, this is not a one-size-fits-all solution. It just does not work that way.

Indeed, I will tell you, our hospitals have done an amazing job of reducing cost cutting, changing practices. Now we are really at a point where quality of care is impacted. But, as an administrator, you cannot make a decision over the long term because we do not even know what the fix is going to be for this year.

They do not know what the returns are going to be. You do not have a revenue stream. You cannot plan. You cannot hold on to good doctors. You cannot go out and find new ones. So we are actually losing practitioners in the greater Boston area now as a consequence of the quality of the delivery structure itself.

So, I just would say to you, Mr. Secretary and Mr. Chairman, this committee, I hope, this year will work diligently with you. We politicians have got to bite the bullet. We cannot allow this issue to become the sort of political ping-pong ball that gets tapped back and forth, with the ultimate result that politics is played well but policy is terrible. I hope we will do that with you.

But it is going to require us to be a little bit courageous and stand up and tell some truth to the American people about what costs matter and how we can structure this thing better. I certainly hope we will do that with you.

Secretary THOMPSON. Thank you, Senator Kerry.

The CHAIRMAN. Thank you very much, Senator. In fact, the bill you referred to that you are introducing along with Senator Murkowski is legislation that I am seriously looking at. It will probably need some modifications, but it is certainly a step in the right direction. I hope to include it in the bill that we report out.

Senator KERRY. I appreciate that, Mr. Chairman.

If I could also encourage you to perhaps embrace the Nursing Reinvestment Act as a component of that, too, which has bipartisan support. But I would like to look at that and talk to you about that also, Mr. Secretary.

The CHAIRMAN. Thank you.

Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A. U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman.

I commend you, Tommy, for the work you are doing. Let me just say, briefly, I commend both you and Tom Scully for your commitment to make CMMS—I am going to call it CMMS now.

Secretary THOMPSON. That is a good name.

Senator HATCH. That is a good thing, you think?

Secretary THOMPSON. Yes.

Senator HATCH. I like the way you answer questions and make comments. But I am pleased with your commitment to make this agency work better and more responsive to the beneficiaries, to the providers, to Congress.

If there is anyone in this town that can make significant improvements to this particular agency, it would certainly be you and Tom. I have great respect and confidence that you will make this happen. I want you to know that I will work with you to help in any way I can to make it happen.

Now, first of all, let me say that you have got a really tough job, Mr. Secretary, in many respects. This committee, I think, is going to be a committee that will help you fulfill the responsibilities that you have and do the things that you want to do.

Mr. Scully has a very difficult job. I personally think that CMMS can become much more efficient, do a much better job, and be much less intrusive and bureaucratic than it has been in the past, and I am hopeful that you can help bring about those kind of changes.

But I have great respect for both of you. With that, I will end.

The CHAIRMAN. Thank you very much, Senator.

All right. Mr. Secretary, I would like to hear your statement. I might say, before you begin, you came to this town as a man with a reputation for action, for getting things done, and you are doing it. It is my impression thus far that you have done a heck of a job. You have taken this job on, grabbed the bull by the horns, and you are trying to do your very best.

I also deeply appreciate you being a man of your word. That is something that is very important in life, especially in this town.

Third, I am glad that you are taking the time to travel a little bit and work at different sites in your organization. I understand you spent some time up at Baltimore. You worked out of the Baltimore office for about a week, helping introduce Mr. Scully to his job up there.

I think that is good. I am glad you are doing that. It is going to give you a really good sense of what is going on, it helps morale, and it helps find solutions to problems. I know Mr. Scully is going to be doing the same thing, and I just want to thank you very much.

STATEMENT OF HON. TOMMY THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary THOMPSON. Thank you very much, Senator.

Let me just start out, Chairman Baucus, and just say thank you. Thank you and Senator Grassley, Senator Hatch, Senator Breaux, Senator Conrad, and Senator Kerry. This, to me, this little opportunity to come in front of you and to listen to your opening statements, really helps Tom Scully and myself.

First, I am very impressed with the fact that I have Tom Scully coming out to be the Administrator. He knows the subject, he works hard, and is going to be a tremendous partner with me.

We really want to change. We want to make the Department of Health and Human Services the most responsive department in the Federal Government. These are just the first of many changes that we are going to be making. We would love the opportunity to come back in front of this committee and tell you what we are planning and what we intend to do.

In regards to what you were talking about, Medicare reform and prescription drugs, I wanted to get up and cheer you, Senator Bau-

cus, and tell you that that is exactly what has to be done. We have to do it on a bipartisan basis. We want to be able to help you do that.

Senator Breaux and Senator Conrad, in regard to your statements, we absolutely agree with you in regard to change and helping out rural hospitals and rural practice.

Senator Kerry, the only thing that I differed with in all the statements this morning was the fact that you implied that technology was really at the forefront in the delivery of medical services. It needs to be. I do not think we are there yet. I think we have to do a lot more.

I would like to be able to come back sometime and talk to you and this Finance Committee about what we intend to do and what we need to do to drive more technology in the delivery of medical services in America. I think we are way behind and we have to do a lot better job.

Senator Grassley and Senator Hatch, I applaud you and thank you so very much.

I want to give you a short statement and then I am going to ask Tom Scully to also give a few remarks. But we have lots of ideas that we want to bounce off this committee in the future, and hope that we will have the opportunity, Chairman Baucus, to come back and work with you and give you our ideas. If they do not measure up, we will reject them.

The CHAIRMAN. I think that is a good idea. I think it is good to set some benchmarks, and then at a subsequent date come back and see how we are doing and what we need to do to make changes. It is important to keep driving this dialogue and keep it going. I appreciate that, and we will do so.

Secretary THOMPSON. I did spent a week up at HCFA. I told the individuals up there that everybody hates you. When I went through the confirmation process, Republicans, Democrats, Independents disliked and said, you know, you have got to change HCFA. You cannot change HCFA without changing the name because there is such a feeling of distrust and dislike and abuse, that it just would not work. So, we had to change the name.

I also moved out this week to HRSA, so every month I am going to go to a different division and spend a week there, actually getting to know the operation, getting to know the employees, and getting a chance to see how the programs are working.

But today I am going to discuss changes that we are bringing to the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration, or HCFA. I told the employees, how could anybody like something called a HCFA? I mean, it is just not warm and it is not really what it is all about, Medicare and Medicaid services for people.

The transformation of the centers which we are proposing to call CMMS, or CMS for short—I like that, Senator Hatch—is part of a larger effort to renew the whole Department of HHS.

We are going to take aggressive, positive steps towards bringing a culture of responsiveness to the department. We intend to reinvigorate the entire department with a spirit of responsiveness.

I have sent a clear message to everyone at HHS, namely that accepting the status quo is not acceptable. The American people deserve excellence. In the new HHS, we hope to give it to them.

We have demanded a renewed dedication to answering people when they need help. When people write us, whether physicians, members of Congress, or ordinary Americans, they should be able to get a quick and accurate response.

To that end, I have directed the Executive Secretary at HHS to develop and implement a new protocol for responding to requests for help and information. They have been charged with clearing away all the backlogged correspondence. Some of it goes back a year, 18 months, but it is supposed to be all cleared up by July 1.

An answer to any letter for my signature must be on my desk within 15 business days of its arrival in my office. Frankly, I think that is too long, but at least it sets a firm time limit.

We are also moving towards a paperless system, Senator Kerry, automation, technology, to speed up our response time. I have insisted that all written material be expressed in plain English. I am a country lawyer. If I cannot understand the rules, I reject them.

If I cannot understand them, I do not expect doctors, hospital administrators, and clinics to be able to understand them either. If we can perform cross-continental surgery using satellite technology, we certainly should be able to explain ourselves clearly and simply.

Responsiveness must extend to States as well. As all of you know, I was a Governor for over 14 years and I know the frustrations that you have, and Governors have, in trying to get help from Washington.

The difficulty lies not with any one group of individuals—because I think we have great employees, I just think they need new direction—but with a system that sometimes seems to put nicely filled out forms, as you have pointed out, Senator Kerry, up here with the books and the forms, ahead of pressing human needs.

Of course, there is a genuine need for some rules and regulations, but rules should exist to help our efforts to help people, not impede them. When regulations obscure, even thwart the help, they need to be changed.

In the past 4 months, I have approved over half of the waivers and State plan amendments, some of which had gone back to 1985. We had some waivers that went back over 15 years.

We are going to have all the backlog cleaned up by September 1, and then all waivers and permits are going to be handled within 90 days. I authorized those waivers because people without immediate needs cannot wait for a rumbling bureaucracy to plod along.

Medicaid and SCHIP waiver requests must be handled promptly so States know where they are going to go, efficiently and with a sense of compassion for the people that they will be benefitting. We will not be satisfied until we develop a process that achieves those goals.

To that end, I am announcing today some important regulatory streamlining measures. Plans, providers, and other stakeholders have raised concerns about the extent, as you have, Senator Kerry, of the regulatory burden and the cost of doing business, Senator Conrad, with Medicare.

We are going to take a number of steps to reduce the unnecessary burden and complexity of requirements. CMMS will move to a quarterly schedule of announcements and directions given to plans and providers instead of coming out willy-nilly. They are going to come out on a quarterly basis so people are going to be able to plan for those changes, bringing more predictability to communications from the agency.

CMMS will pursue electronic rulemaking to make it easier to access and respond to those regulations. We are also forming an ongoing regulatory reform group to look for rules that prevent the physicians and other health care providers from helping people in the most effective way possible.

I talked to the AMA this past Sunday in Chicago. I told them, if you have got a rule and you are frustrated, write to me about it. But just do not write and complain, write to me about a solution. Criticize, but also come up with a solution and we will take that up and see what we can do.

This group will determine what rules need to be streamlined and what rules need to be cut altogether. I am very mindful that, within HHS, we must solve our own technology problems.

For example, CMMS has a mainframe computer system that was launched in 1970. We process a billion claims a year. We have software, processing those claims, that is over 30 years old. Do you know any insurance company, any law office, any office dealing in any business with software that is 30 years old? We are a $375 billion agency and we have software processing claims across America. We are an accident waiting to happen.

We are going to be able to hopefully improve and be able to bring in a new computer system at CMMS that is going to be able to use the newest technology.

The transformation of the Department of Health and Human Services has begun. It is going to take time and it is going to demand some expenditure of resources, but it can be done, and it is going to be done. There is no place where the transformation is more critical than at CMMS.

Tom and I are committed to ensuring that CMMS is more responsive to our provider partners, to the Congress, to the States, and the tens of millions of Americans who depend upon them on a daily basis.

We want to work with this committee—this is a very important committee for us—and with Congress as a whole in a bipartisan fashion because today what I heard was that everybody wants to help, Democrats and Republicans. That was music to my ears. We want to be able to accomplish our objectives so that these critical programs are prepared to meet not only today's needs, but tomorrow's challenges.

We will reorganize the Centers for Medicare and Medicaid Services into three centers that more clearly reflect what precisely the centers do and how they should be serving the millions of Americans better.

The first one, is the Center for Beneficiary Choices. It is going to focus on the Medicare+Choice program and provide beneficiaries with information they need to make a wise choice in choosing what is best for them.

The second, will be the Center for Medicare Management. That is going to focus on the traditional fee-for-service Medicare program. Then the third one, will be the Center for Medicaid and State Operations. This will focus on programs administered by the States, including Medicaid, SCHIP, as well as insurance regulations.

To make the agency more consumer-friendly, we will name a Medicaid SCHIP contact for each State at our regional main office to cut through bureaucratic bottlenecks.

Each State will have one person they deal with and with whom their representatives will build a long-term relationship. So, in your case, Senator Conrad, the hospitals will be able to have one person they can contact.

We are going to select senior HHS staff members to be able to serve as primary contacts for beneficiaries groups, physicians, providers, and suppliers.

We will also find better ways to resolve problems, increase training and education, which is absolutely vital in order to respond to Congress and other groups more promptly.

However, these changes will be for naught if we cannot reach the people we are here to serve, the beneficiaries who we are set up to serve, to ensure they understand what services are available to them. Too many of the people I have met around the country as Secretary and as Governor tell me they do not understand what services are available to them.

Consider just the multiple programs that currently exist: Medicare, Medigap, Medicare Select, Medicare+Choice. That is a lot to keep straight. We need to do a better job of explaining these programs and help people make more informed health care decisions.

During this open enrollment period this fall, we are going to launch a major media campaign, Senator Grassley, to highlight the health care options and resources available to Medicare clients.

This campaign will begin this fall and is the brain child of Tom Scully. It is going to be a very important tool in reaching beneficiaries.

This fall, we are also going to make the 1–800 Medicare phone line available 24 hours a day, 7 days a week, so callers in Utah will be able to call in and get their answer anytime during the day, Senator Hatch, and will be able to receive information about health plan options available in that respective area.

We are going to improve the Medicare Web site to help beneficiaries compare benefits and the quality of the providers. We will propose grants to public libraries and train librarians to assist seniors in being able to obtain information about Medicare.

Finally, we want, Mr. Chairman, to be able to pursue Medicare contracting reform. I talked to you about this when I came in front of you on the budget several weeks ago.

We need to reform the legislation to reduce the number of private health insurance companies that process claims and provide other administrative services from 49, to date, to down to no more than 20 by 2006. We have just too many and we have no discretion in being able to find the best providers, so we need to change that.

We should be able to award these contracts on a competitive basis, and on the basis of performance-based contracts, instead of

just based upon costs. This standard will allow us to improve service and quality to beneficiaries and providers.

I want to work with each of you, as Tom does, to ensure that this is done efficiently and in an effective manner. This needs to have your approval. It has got to be changed by a statute, and I hope that we will be able to do it this year.

These ambitious, but crucial, proposals, and one that will determine the future effectiveness of the Centers for Medicare and Medicaid Services. As I have said throughout my remarks today, we must not remain entrenched in the old way of doing things.

We must always be willing to change our new name that certainly reflects a new attitude and more apt description of what our agency does, administer Medicare and Medicaid.

But, as I said at the beginning of these comments, our real goal is not just to make the trains run a little bit more on time, but actually to fulfill our duty as a department, to serve our fellow citizens faithfully and well.

We are here to provide essential services to millions of health care consumers and the providers that serve them, and to the Congress that actually implements them and are our bosses. We want to be able to provide these services at a level of excellence that Americans deserve.

This is just the beginning. We are going to continue to strengthen and modernize CMMS, as well as the whole department, as long as I am there. That is my pledge to each of you. I also pledge to work with you on a bipartisan basis to be successful in all of these regards.

I want to thank you, Mr. Chairman. Now I would like to ask my Administrator, Tom Scully, to make short remarks also.

The CHAIRMAN. Thank you very much, Mr. Secretary.

[The prepared statement of Secretary Thompson appears in the appendix.]

The CHAIRMAN. Mr. Scully?

STATEMENT OF THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. SCULLY. Mr. Chairman, thanks. I will be very brief.

First, I would like to say it is great to have a boss who likes to change and shake things up. It makes things a lot easier. It has been a very entertaining, and hopefully semi-fruitful, first month.

I have spent almost 20 years working with the Finance Committee, and certainly with every Senator that is here today, and had terrific experience on lots and lots of legislative issues. So, I look forward to working with all of you and your staff to accomplish a lot.

I think we had the entire staff up to the agency formerly known as HCFA, CMS, about a month ago. I think it was great for them, and I hope we can do a lot more of that.

The place needs change. There are great people there, the Secretary found that out. They are kind of looking for direction to do things differently.

Just one example. This past Friday, Houston, as you probably know, had a lot of hospitals close for floods. One of them had a transplant center that shut down and they wanted to move it half

a mile to a sister hospital for transplants. The initial answer was no.

So, we shook things up a little bit. In the course of about 12 hours we got it turned around, and we moved the transplant center. But the actual rules and statute did not allow for that. The people down there got a little frustrated, and we found some creative ways to do new things.

I think generally the people at CMS want to do the right thing. They are terrificly talented. They are just not used to finding more creative ways to get things done. I think, with the Secretary's very strong guidance, it has been a huge help in getting them to think outside the box and has been very helpful.

I think one of the frustrations, having been on the Hill myself before, and I know from many of you, is the responsiveness of HCFA to Congress. Within HCFA, the average letter from a member of the House or Senate was about five and a half months this spring. We have gotten that down to 14 days, 15 days, I hope, that I am aware of right now. That is certainly our goal.

We have set a goal as well, for the end of the summer, to have every Congressional request that comes in responded to in 14 days. So, I hope you will see some responsiveness on that.

The Secretary already mentioned the idea with the States. The States, I think, get as frustrated as you do that they cannot get a straight answer. We have pushed very hard to get one human being at the regional offices and one in Baltimore who is going to be responsive to them, and will be responsive to the Secretary and to me.

So if a State has a frustration, obviously, you cannot give everybody the answer they want all the time, but they should get straight answers, and hopefully they will.

Finally, I would just say my favorite project is this education campaign, as the Secretary mentioned. I found from our polling when I first came in—we do very significant polling, and have for years—of Medicare beneficiaries that over 50 percent of them have no idea what their options are.

It is not just Medicare+Choice, it is Medigap. As much as anything else, it is Medigap, which is obviously very prevalent among seniors. They just flat-out do not understand their options.

So our goal this fall is to educate all seniors about all their options, whether it is just Medigap, which most seniors do have, Medicare+Choice, Medicare Select, our goal is to have very, very educated seniors.

As some of you know, we have pushed back, for instance, in the Medicare+Choice program, the ACR filing date to try to keep more Medicare+Choice plans in, because a lot of them are dropping out. That was part of the decision, we also thought we had to really go the extra mile to really, really push to educate beneficiaries this fall.

So, I hope it will work. We are investing a lot of money in it. We certainly would love guidance from you on how to do it. We are getting the project started this week and hopefully you will find a much more educated, much more informed group of beneficiaries by Christmas time.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Scully. I think you will find this committee and this Congress very willing to work with you to solve these problems. I think the time has finally come.

Sometimes a problem has to get so great, the confusion is just so impossible, that a crisis emerges and we finally get together and put partisan politics aside and quit the carping and complaining and roll up our sleeves and get the job done. I think that time has arrived.

In listening to you, I was struck, first, with your energy and dedication that you have taken to solve all of the various problems surrounding CMS. I was also struck by the ambitious nature of your plans. That is, there is a lot that you need to do and want to do.

It would be helpful for me to know what your priorities are and what your time tables are for the various proposals that you mentioned, so that down the road we can go back and look to see how well you have progressed and what we still need to do.

There is a lot we have to do here. We all want to help you do it, but we need a sense of how long it is going to take and what we can do to help organize this and make sure that it gets done this time.

Secretary THOMPSON. Well, first off, the name change and the rule changes that we are in the process of, the publicity campaign that will be done this fall, all of this.

The name change is going to be phased in because, being conservative, we do not want to waste all of the stationery we have. So, we are going to phase it in. When we use up the HCFA stationery, then we will reprint some other stuff so we do not have to come back and ask you for any money to do this. We are going to be changing it in incremental steps.

In regard to the bookkeeping system, the bookkeeping system is terrible at the Centers for Medicare and Medicaid Services. We still have a single-entry bookkeeping type of system, and it needs to be changed.

It is called HIGLAS. That is in this budget. I think we asked for $36 million. Hopefully, Congress will give us that amount of money. That is going to take about 3 years to implement a brand-new bookkeeping system for the whole department.

Then the computer system. We have got to get started on that this fall. We are going to try and fund what needs to be funded internally, but that is going to be a huge overall expenditure. We have over 200 different computer systems in the Department of Health and Human Services, a lot of which cannot communicate with one another. What we need to do is centralize a brand-new, high-tech computer system.

The software system, I would like to be able to get changed over the course of the next 12 months because it is extremely important is the one that is processing the claims.

I think it would be an embarrassment, especially for the department but I think it would spill over on Congress, if we have a breakdown in the processing of claims. So, that is important and we need some money for that.

In regard to the contracting, this is something that we are asking you to help us with, Chairman Baucus. It is going to be controver-

sial. I am not coming in here to tell you that it is not going to be controversial, because the people who have contracts right now will not want to have to compete on a wholesale level, and it is important for us to do so.

I think it is going to be easier to change the way we contract with claims processors. I think there is a much better way to do it, but that is going to have to depend upon how soon Congress will introduce a bill and help us on it.

The CHAIRMAN. I wonder if you could do this for us, please. First, list the changes that you plan to make administratively for the record, and then send us a letter in the next couple of weeks or something to outline this, and their priority, along with time lines indicating when you think you can get them accomplished.

Secretary THOMPSON. Absolutely. We will be more than happy to do so.

The CHAIRMAN. Next, list the legislative changes. If you could prioritize those, too, which ones you think are most important for improving service to beneficaries. And which of the legislative suggestions do you think make the most sense?

While we are at it, an obvious question a lot of us have, is how well can the agency take on additional work, additional charges, additional mandates? I know a lot of us believe that CMS is already strapped, and then Congress comes along and gives it new responsibilities.

Now we are talking about adding prescription drug benefits. We have talked about Medicare reform. The Balanced Budget Act has not totally worked its way through yet. What is your sense on how easily we could do all this?

[The information referred to above can be found in the appendix on page 108.]

Secretary THOMPSON. Chairman Baucus, you have raised a very valid point. I do not think we can do much more with the amount of resources, the amount of technology that we have.

We are sort of at the bending point of saying that we cannot do any more. I am not being critical, because that is not my style. I want to come here and point out a plan on how we can be able to be helpful.

But it seems that in the past there has been such a distrust and dislike of HCFA, that every time Congress did not have an idea where they wanted to put a proposal they gave it to HCFA, but no additional resources. HCFA, right now, is overloaded with HIPAA and with the privacy rules and regulations, with Medicare and Medicaid, and SCHIP, and so on. I do not think we can really take on any more responsibilities.

The CHAIRMAN. Well, what do we say to the seniors in our country who need a prescription drug benefit? Seniors in my State of Montana—I daresay this is true in other parts of the country—who are not covered pay more in prescription drug costs than do seniors in any other part of the civilized world.

Secretary THOMPSON. I am saying that prescription drugs, with the reform of Medicare, we can handle that. But I am not saying additional programs, I am saying Medicare. That is our primary reason for existing, so we have to do that. We have to do prescrip-

tion drugs. That is why the Centers for Medicare and Medicaid Services were set up. That is number one.

I am saying, additional responsibilities beyond that, at this point in time, I do not think we can do unless we get additional resources. But reformation of Medicare, with a prescription drug component, we have to do that.

The CHAIRMAN. Thank you.

Senator Grassley?

Senator GRASSLEY. I join the Chairman in welcoming and applauding your enthusiasm as you approach this very important job of making an agency a very effective agency.

I think you probably answered the concern that I would have with most people in any position of leadership, either you run the organization or it will run you. So, I am pleased that you are taking this very important role of knowing that you are in charge and are going to do what needs to be done.

I am pleased to hear you speak about the need to ease regulatory burdens on Medicare providers. I am also committed to see that the Medicare program improves in a way that relates to both beneficiaries and providers, specifically the need for improved communication and coordination between the center CMMS office and its regional offices and contractors, also improving the dispute resolution process, and lastly, improving communication to the beneficiaries. These are all issues that come up regularly, so it is very good to see you working on these.

I understand some of these concerns may be addressed administratively, others will require legislation. You are going to outline that, as you just indicated to Senator Baucus. But hopefully we can work together to determine which areas are in need of legislation, then we can help in that area very quickly.

If you are able to elaborate, I would be interested in hearing some of your ideas on easing the paperwork burden and improving communication between CMMS and providers.

Secretary THOMPSON. We have good communication routes set up in all of our divisions that are not being utilized, and I want to utilize them, Senator Grassley. I want to be able to put out programs for providers, especially for the physicians, hospitals, and clinics across America, throughout these three centers for what these programs are all about. I want to be able to do that on a regular basis.

We also want to be able to set out this communication program this fall that Tom Scully outlined that is going to be able to really give the information to our senior citizens about what is available and how they can interact, and be able to set up this hotline, that any time a senior wants to call us throughout the day or evening, they will have the opportunity to do so, and have somebody there that can give them a correct answer on a quick, efficient basis. This is our overall plan.

Senator GRASSLEY. Could you also address your efforts to reduce the paperwork burden? We hear that more from nurses at nursing homes, nurses in hospitals, doctors. We hear that an awful lot. I assume that is the kind of paperwork reduction you are talking about.

Secretary THOMPSON. Absolutely. Absolutely. We are trying, Senator Grassley, to be able to put our rules and regulations in simple,

straightforward language that the common person can understand. They are so confusing. When they come up to my desk and I cannot understand them, I ship them back.

Senator GRASSLEY. You do not need to elaborate, but have you identified specific things that need to be done in that area or are you still exploring?

Secretary THOMPSON. No. We have identified some, but we are exploring at the same time. We are setting up a regulatory commission, but at the same time we are simplifying. Tom, you may want to comment.

Mr. SCULLY. First, what the Secretary announced today, and this is a fairly simple step. Providers get regulatory announcements 30 days a month. So one thing we are going to do, is we are going to put out a compendium at the beginning of each quarter which will list anything that is going to come out that quarter from HCFA, whether it is a regulation or just guidance. Then we are only going to put out all of our guidance, unless there is some emergency—this is kind of a self-imposed restraint—1 day a month. So, it will be one day a month that you will get everything from HCFA.

The reason for that, having been in the provider community in the past, is you are not going to have to look at the Federal Register every day, you will have to look once a month. You will also know, in the compendium, if something is coming that quarter.

You will get a list at the beginning of the quarter of everything that is on the agenda for that quarter, so you will not get any more surprises and you will not have to have every provider in the country hire a lawyer to read the Federal Register every day. That is a fairly simple reform, but I think it is a first step and I think it will be helpful.

Senator GRASSLEY. Thank you.

Secretary Thompson, as you know, this week we are going to be considering the Patient's Bill of Rights. Some of the proposals we have heard include a greatly expanded role for CMMS in regulating private health insurance plans. HCFA was given a similar task in 1996 by the Health Insurance Portability and Accountability Act, HIPAA, we call it.

My perception, is that the agency has really struggled with that function, which is quite different from the core Medicare and Medicaid tasks. What are your thoughts on the wisdom of adding more responsibilities in this area to CMMS?

Secretary THOMPSON. I am certainly not encouraging any more additional oversight as far as HIPAA is concerned, or the Patient Bill of Rights, at the Centers for Medicare and Medicaid Services.

I think, as I mentioned to Chairman Baucus, we are at the end point as far as assuming more responsibilities, especially with the fact that our primary objective is prescription drugs and reforming and strengthening Medicare. We have to do that, and that is what we want to do. Adding additional things at this time for CMMS, I do not think, is something that we are going to be able to do as well as I would like to be able to them. I do not like to take on things unless I am going to be able to do them. I want to be up front about that.

In HIPAA, we are still struggling. There are four items in HIPAA that we are supposed to be regulating at the State level

and we are not doing a very good job yet. That is because we did not have the additional resources when HIPAA was passed to do that and we have had to try to internalize it, and we have not been very effective at it as of yet.

Senator GRASSLEY. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you, Senator.

Next on the list is Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Mr. Secretary and Mr. Scully, for your presentations.

Where do you start? I have got so many places we could start with your agency. I will start with one idea. Mr. Scully, if you are going to be an average Administrator, you have only got about 10 months left. [Laughter.]

Mr. SCULLY. I think my wife might help with that.

Senator BREAUX. The average tenure of a HCFA Administrator is 1 year. You wonder why we have a problem with continuity within an agency where the average Administrator survives 12 months, and then they put somebody else in.

Most times, we operate this entire agency with an acting Administrator. That does not give a lot of confidence as far as the people that you have to work with, the people that work with you as well as all the providers that you have to deal with.

So, I would hope that you will be able to break the average and stay there for a period of time to give you an opportunity to do some things which I think need to be done.

You have got a good team, Mr. Secretary. Utilize them.

I forget who made the comment, but it is going to run you if you do not run it. The people in any bureaucracy know that they are going to be there a lot longer than you.

Secretary THOMPSON. That is true.

Senator BREAUX. Political appointees come and go, but they are going to be there forever. It is very, very important to have an attitude that you are going to make changes as quickly as you can and get them done.

There are all kinds of areas when you are dealing with 133,000 pages of regulations. We are still dealing with things that we passed in 1997 which have not been put in final regulatory form today.

Secretary THOMPSON. Absolutely.

Senator BREAUX. I mean, I am thinking of the diabetes self management training. That is still not finalized, and we passed that in 1997. So, the things that we do in Congress take years to even get through the system.

Let me talk about a bigger picture, though. That is, there are some of us that believe Medicare+Choice could never work because of the way it was managed within HHS and within HCFA.

What Congress was essentially saying, is we want a new competitive system to compete with the government, but the government is going to run it. If I can be the referee, I am never going to lose. I am always going to win. I think that is what happened with Medicare+Choice.

So I want to understand the new boxes that you are proposing. You are creating a Center for Beneficiary Choices, one box. You are

creating a Center for Medicare Management, another box. And then the Center for Medicaid and State Operations.

My understanding from your testimony is that the Center for Beneficiary Choices would be the organization within CMMS that will manage the traditional fee-for-service. Is that correct?

Secretary THOMPSON. No. The Center for Management. The Center for Beneficiary Choices will have all the choices in it. The fee-for-service will be in the second center.

Senator BREAUX. All right. The Center for Medicare Management will be the traditional fee-for-service program.

Secretary THOMPSON. That is correct.

Senator BREAUX. All right. So you will have a Center for Medicare Management which will run you traditional fee-for-service programs as we know it under Medicare today.

Then the new Center for Beneficiary Choices will be in charge of what is now known as Medicare+Choice, a competitive system that will compete with traditional fee-for-service.

Secretary THOMPSON. That is correct.

Senator BREAUX. Both of those boxes will be under HCFA/CMMS or under HHS?

Secretary THOMPSON. They will all be under HHS, but they will be directed by CMMS.

Senator BREAUX. So how is that going to be any different from what we have now where the fee-for-service competes with Medicare+Choice under HCFA? Is this not the same thing? How is this any different?

Mr. SCULLY. It is broken out within HCFA. Currently, the Center for Health Plans and Providers is basically jointly managed by the same group of people, so these are definitely two different blocks.

The Center for Beneficiary Choices is not only the Medicare+Choice program, is also all the beneficiaries educational services. We already expend quite a bit of money every year on beneficiary education as it is. Basically, they are existing pieces of the old HCFA that are put together under CMS in places that we thought would work well.

Senator BREAUX. You have different people in the two different blocks?

Mr. SCULLY. There are in fact, a number of senior people at HCFA switching around to run that center. In fact, we actually have not hired a political person to run that center, but Michael McMullen, who has been the Acting Administrator for 6 months, will be over there temporarily running it.

Senator BREAUX. If Congress creates a prescription drug program, where does it go under this new arrangement, what you would recommend?

Mr. SCULLY. I believe it depends. In the Medicare+Choice program, I think that would be under the Center for Beneficiary Choices sector, obviously absent legislative direction, and under the Center for Medicare Management area for the fee-for-service. So, if it was an addition to the fee-for-service area, it would be in that.

Senator BREAUX. We could spend a lot more time on all of this, obviously.

Secretary THOMPSON. Senator Breaux?

Senator BREAUX. Mr. Secretary?

Secretary THOMPSON. Senator Breaux, I would like to point out, this is the first giant step, but this is not the last one. We are looking at the whole structure of the Medicare+Choice program. We may be coming back with some other ideas about splitting it out, we may be coming back asking you for some support in hiring a professional private manager.

But those decisions have not been made. I just want you to know that this is not the end. This is an ongoing process to improve the quality and the efficiencies of the services of all three of the centers.

Senator BREAUX. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

First of all, let me just say to you, Mr. Secretary, I like your attitude. I like it a lot. We need to have some energy there and some feeling that we are going to do things differently. Setting specific goals, that is exactly what is needed and I applaud you for it. I am just delighted to hear your discussion here this morning.

I could not be more pleased that you have as an Administrator Mr. Scully. Many of us have worked with him on a bipartisan basis for years. When I heard he was being considered, I knew it was a substantial personal sacrifice and I urged him to take this on.

Secretary THOMPSON. I am glad you did, Senator Conrad.

Senator CONRAD. That almost discouraged him. [Laughter.] But this is important. This really matters in people's lives, so doing our best is important.

I want to go back to where I started my opening statement and just briefly go through a couple of things. Then I am going to ask you about legislation that, now, 20 of us have introduced.

It is truly bipartisan. My staff informs me, as of this morning, there are 10 Democrats, 9 Republicans, and 1 Independent on this bill. So, we have got all of the elements.

Let me just go back to this Medicare disparity. The blue bar is Mercy Hospital in Devil's Lake, North Dakota. The red bar is Lady of Mercy Hospital in New York City. Simple pneumonia, $8,500—nearly $8,600—in New York, $4,200 in Devil's Lake, North Dakota.

My dear friend Senator Breaux says, well, it costs a lot more to live in New York. It does cost more to live in New York. But the delivery of medical services is not a 100 percent difference.

When we have to buy technology we do not get a discount because we live in Devil's Lake. The difference in the labor rates, while there is a difference and it is a significant difference, it is not a 100 percent difference. Yet, we are left with a 100 percent differential here. The same is true on heart failure, 2:1.

Let me go to the next one. Here is the result. Inpatient margins. The aqua bar is urban hospitals, the dark blue bar is rural hospitals. Almost 3:1 in terms of their margins. This is according to MEDPAC's analysis of HCFA data, CMMS data, now.

On overall margins, look at the difference here. Rural hospitals have a negative 3 percent margin on Medicare patients. Now, you cannot survive very long on that.

This chart makes that point. This is the percentage of hospitals by the number of discharges per year, percent with losses. The aqua bar is those hospitals with 200 or less in discharges. Look. Almost 70 percent of those institutions are losing money. It steps right down from 201 to 500, the blue bar, where over 50 percent are experiencing losses.

Now, we cannot go on this way. I can tell you that, in rural settings, these hospitals are going broke. Most of them average 70 percent Medicare-eligible patients. That is their patient make-up.

So, the legislation that we have introduced, 20 Senators and more than 30 House members, again, about evenly divided in both the House and the Senate in terms of party membership, this is what it would do. It would close up those margins.

Instead of a 3:1 on inpatient margins, urban institutions over rural, we would close the gap. We would close the gap. We would not eliminate it, but we would close it.

I just want to ask you if you would take a look at this legislation, it is Senate bill 1030, and give us your impressions. Is this something the administration could support? What changes would you recommend?

The second point I want to get to, is this question of Medicare payment delays. I indicated we were having hospitals with 3 months of backlog. Last year, Congress provided the agency a 32 percent increase in administrative resources to be used for improving these services. It was a $1.3 billion increase.

Could you give us some idea on how you are using that increase to improve Medicare contracting services?

Secretary THOMPSON. I would say that the best thing we could do to improve the quality of contracting and be able to get the payments out, is to have the contracts put out on on a performance base, and merit base, and so on, instead of cost, and be able to reduce the number of contract fiscal intermediaries, as well as carriers.

If we can reduce that and put the contracts out on performance and allow anybody to bid on them, I am confident we could improve that system considerably.

In regard to rural hospitals versus urban hospitals, as I mentioned to you when I was in front of you for confirmation as well as for the budget, I told you that I come from a very small rural community, population 1,400.

My home hospital is in a very rural area, suffering the same problems that you have pointed out. I want to be able to help that hospital like you want to help all the hospitals in your State. I want to do it for all the small rural hospitals in America.

I would love to look at your legislation and make suggestions. We will be back to you within our 14 business days with an answer, Senator Conrad. Tom and I both will respond to it.

Senator CONRAD. All right. I appreciate that very much.

The CHAIRMAN. Thank you very much, Senator.

Senator Kerry is not here. Senator Hatch?

Senator HATCH. I am glad Senator Conrad brought that up. Utah, in particular. There is a disparity even among rural States. Utah is not treated very fairly on reimbursement rates, and it is

very similar to what North Dakota has to face. So, this is a really important issue to try and resolve.

First of all, let me say that I want to commend you, Mr. Secretary, for the outstanding work you are doing to make the agency run more efficiently, and your obvious commitment to improving many aspects of the overall management of CMMS.

Clearly, this job is extremely difficult. You and Tom Scully have a very, very big job ahead of you. But you are definitely on the right track. I want you to know that I will do everything I can to help you to make the agency better, and will certainly do what I can to address that objective.

Now, I know you addressed some of my questions in your testimony, but I am compelled to raise just a few issues because they remain outstanding issues for me, and for other members of this committee.

Specifically, I am concerned about your thoughts on contractor reform. Medicare contractors work in partnership with CMMS and they are a very major part in dealing with providers. Frankly, one of the most common complaints that I hear from Medicare providers are problems that they have with their contractors.

Now, these problems range from disputes over reimbursements or withholding of payments to simple matters involving returning phone calls or being able to talk to someone, anyone, who really knows what they are talking about.

Would you discuss in just a little more detail your thoughts on improving contractor performance and what efforts you will pursue to improve customer service to providers?

Secretary THOMPSON. First off, we want to put one person in every State out of the regional office.

Senator HATCH. I like that idea.

Secretary THOMPSON. So they are going to be able to have a contact person that they know, in Utah, that that person represents Utah.

The CHAIRMAN. When will that occur, by what date? When will each of us in our States know who that person is?

Secretary THOMPSON. Tom has got it.

The CHAIRMAN. It is all right there?

Mr. SCULLY. Yes.

The CHAIRMAN. Good.

Senator HATCH. Well, it would be nice for us to know today then.

The CHAIRMAN. Who do you have for Utah?

Mr. SCULLY. For Utah, it is Aaron Blight in the Baltimore office, and Tilly Roland in the regional office, which is Denver.

The CHAIRMAN. Why don't you read those for the Senators who are here. This is not on your time.

Mr. SCULLY. We can give you this. We have a more detailed one with names and phone numbers.

The CHAIRMAN. Well, who do you have for Arkansas?

Mr. SCULLY. For Arkansas, in the central office, which is Baltimore, it is Marty Svolos. In the regional office, it is Ford Blunt, which is the Dallas regional office.

The CHAIRMAN. All right.

And for Louisiana?

Mr. SCULLY. For Louisiana, it is Wayne Smith in Baltimore, and Joe Reeder in the regional office.

The CHAIRMAN. All right. Oh, good. I have a copy in front of me.

Mr. SCULLY. There is also about a 15-page list of the same people with phone numbers, e-mail lists, and other things. So, hopefully they are all preparing for this onslaught.

The CHAIRMAN. All right. Good. Can you make this available for all the Senators so we know who our people are?

Senator CONRAD. I would like to have a copy.

The CHAIRMAN. Good. Thank you.

Secretary THOMPSON. Can I just expand a little bit further?

The CHAIRMAN. Sure.

Secretary THOMPSON. When Medicare was passed in 1965, there was an agreement with the hospitals and with the AMA that they were able to nominate individuals to be the fiscal intermediaries from a particular State, from a particular hospital, and from a particular clinic. It evolved out of that, in order to get Medicare passed, that that was written into the law.

The contracts are put out on how much it costs to deliver the services. There is no uniformity, as the decision is made by the fiscal intermediaries or the carriers. What Tom and I are trying to do, is change the law, Senator Hatch, so that we could put it out on performance contracts and be able to reduce the number of fiscal intermediaries, because we do not need 50. We do not need 50 carriers.

When you have that many, you have a disparity as to what is paid and what is not paid. It causes confusion and frustration when some doctor gets paid for something from this fiscal intermediary and does not from this one.

Then, finally, we have 30-year-old software that is in the process of paying out these claims. That is an accident waiting to happen, as I mentioned.

So, what we are trying to do is reorganize and reauthorize the contracting provisions so that we can put out contracts and limit the number of individuals, and put them out in RFPs based upon performance. We think we can get a better product, more uniformity, and faster services to the providers. That is what we are asking for.

Senator HATCH. Well, let me just raise one other area of concern to me, because my time is running out. It is the role of the department's efforts in addressing fraud and abuse. As you know, health care fraud and abuse is a very serious issue, and one that I am particularly concerned about.

In 1996, I was very instrumental in developing the fraud and abuse provisions in the Health Insurance Portability and Accountability Act, which dedicated a special fund for fraud and abuse activities.

Now, these new provisions have empowered HHS and the Justice Department with significant tools to address this problem. Moreover, providers are now more diligent in their implementation of effective compliance programs, which is what they should be doing.

Nevertheless, I have heard concerns among the provider community about the perception that these fraud and abuse efforts have been carried to extremes. In fact, some Medicare providers tell me

that they perceive Medicare as overly aggressive and claim that it has had a chilling effect on the provision of care and provider participation.

They allege that there has been an impression that the law enforcement agencies are operating under the assumption that every provider is likely guilty of something and that they can be assumed to be guilty until proven innocent.

Now, this sentiment apparently carries down to the contractor level as well. I know this question is just a little bit outside the scope of this hearing, but I wanted to bring it to your attention because I think it is something we need to keep in focus as we look at reforming this agency.

I would appreciate any thoughts you have on the subject of fraud and abuse activities.

Secretary THOMPSON. Well, Senator Hatch, there are some serious questions about fraud and abuse in the Medicare system, and in the Medicaid system as well. We want to be able to do our part to prevent it.

I think one of the best ways we can help and educate people is through our centers, and put out educational programs, simplify the rules and regulations, have more uniformity in the decision making at the contracting basis as well as at the fiscal intermediary stage, and be able to put out better and more frequent educational programs to doctors, to hospitals, and to other providers through these three centers.

We got the telecommunication equipment set up on the Centers for Medicare and Medicaid Services, and we should be using that equipment better and interactively to get the information out. We think we can do a much better job. We think we can also, in the same process, reduce fraud and abuse.

Senator HATCH. Thank you.

Did you care to add anything, Mr. Scully?

Mr. SCULLY. I would just say, there is a lot that can be done. Obviously, I have heard, since I used to be on the provider side, a lot of the same things. I was the Compliance Committee chair on two different companies the last 4 years. I think some of that is legitimate, some of it is probably a little overdone as well.

I think one of the things that is important, is the Justice Department, HCFA/CMS, and the IG have really always worked together on this. I think Janet Renquist, the new Inspector General nominee will be very helpful. She happened to be a classmate of mine in college. I have known her for 20 years, so I think we will have a good relationship, hopefully.

Senator HATCH. And a former staffer of mine, by the way. She is really very good.

Mr. SCULLY. Yes. Former UVA person. Finally, the Justice Department, with Attorney General Ashcroft. Generally, they have had a health care person over there. I think the three agencies, working together to make sure that the fraud and abuse guidelines and implementation are consistent, is really important.

So, I think Justice is also looking at some people for that post. But I think the three agencies working together consistently is really the key to making sure you have fair enforcement.

Senator HATCH. Well, thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary, Mr. Scully, for being here today. Mr. Secretary, I want to commend you for your very vigorous leadership in revamping HCFA, or former HCFA. I commend you, because it is long overdue.

Obviously it has been an area that has been a source of contention and controversy for quite some time, so I really applaud you for the effort that you are making in your early tenure as Secretary.

Let me just get back to the issue of the paperwork burden. You mentioned in your initial statement about taking swift action to reduce the unnecessary paperwork burden.

It is interesting. Not too long ago, a small hospital of mine in Maine, about 15 beds, which also has home health care responsibilities as well and they serve about 100 patients a day, and the administrator of the hospital happened to bring me the number of forms that are required for them to fill out, for all patients, not just Medicare patients. Just anybody who serves and provides home health care, obviously, gets Medicare dollars.

Here are the forms for a patient, just one patient. These forms extend 56 feet. There are 61 pages of forms. In fact, they had circulated this around the room that I was in with 40 hospital administrators and it went around the room. I mean, that is 56 feet long for just one patient. Then it is required, not just for Medicare patients, but for all patients in that institution. So that is what we are dealing with here.

Up until 1999, it was about three pages of forms. Then there was a requirement for 90 different questions and forms to be filled out that results in this extensive list here today.

So, obviously it is preposterous. It is demoralizing, it is costly. It prevents health care providers from doing what they need to do. Obviously, some information is important and critical to the outcome and what they are doing. Obviously, we need to have accountability. But this goes, I think, beyond any level of principles of responsibility in having them to do this kind of work.

So I think if you can accomplish that, reducing the number of forms, I hope that is in your ultimate priority here. This really borders on the ridiculous, to put anybody through this kind of paperwork requirement for each and every patient.

Secretary THOMPSON. Senator Snowe, there are several things I want to say. First off, thank you for bringing it up. Second, yes, we are very tuned in to the number of forms that we are asking for. Third, to ask for your help. When you pass legislation, be cognizant of what you are requiring us to ask for.

Fourth, I have already put into place some ways in which we can reduce the number of questions that have to be asked every time a patient comes in. If they have to come in on a weekly basis for chemotherapy, we have to ask them the same questions.

One of the questions is, have you got black lung? Well, you did not have it last week, you never worked in the mines. Why do you

keep asking whether or not? It is things like that that are common sense that we are going to be changing, and we are in the process.

Finally, I have got a suggestion. I am sorry Senator Hatch left, since he is very much involved in fraud and abuse. I think hospitals, and I think the delivery of medical services in America, we are way behind, as I mentioned to Senator Kerry.

When you check in a patient or give prescriptions out in a hospital, it is the old-fashioned way. There is new technology out there and we should be using it. There is better technology in checking out groceries in a grocery store than checking in a person in the hospital, or administering drugs. That is not right.

What I am suggesting, Senator Snowe, is a lot of that paperwork could be done away with. We should get to a paperless kind of system in hospitals and clinics. What I am suggesting, is maybe we should take some of the fraud money that we get and plow it back in to best practice and purchase a mini Hill-Burton law to purchase new technology in hospitals to get to a paperless society or paperless hospital on admitting patients and administering drugs.

You would be able to reduce the number of forms, you would do it faster, you would allow nurses to be able to provide health care better instead of filling out forms. You would not be so frustrated, and you would also reduce medical mistakes. Suggestion.

Senator SNOWE. I think that is an excellent idea. In fact, Senator Gramm and I have introduced legislation to adopt the technology to eliminate medical errors when issuing prescriptions in hospitals, for example.

Secretary THOMPSON. Well, consider the idea of setting up a mini Hill-Burton law, using the fraud money to put out in places for new automation, then let us try it. I think we could get to a hospital, paperless kind of clinic, and we would be able to reduce those forms completely.

Senator SNOWE. Good point. That is a good point.

And what about a provider ombudsman in the agency, in your Centers for Medicare and Medicaid Services?

Secretary THOMPSON. We think we are doing that. We are not calling it that, but we think we are doing that by having a person representing each State out in the regions, then having somebody representing the department in Baltimore. I do not know if you were here, but Tom was listing the names.

Who do you have for Maine, Tom?

Mr. SCULLY. This is more for Medicaid. But for Maine, in the central office, it is Roger Buchanan, and for the Boston office, it is Irv Rich.

But we have been talking about a variety of different compliance ideas. We have not quite decided yet as to what idea is the most appropriate one, but I think your ombudsman was one that we have talked about.

The CHAIRMAN. Thank you very much, Senator.

Senator SNOWE. Thank you. Thank you.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. I certainly appreciate you holding this hearing today on the role and the expectation of the newly-named Centers for Medicare and Medicaid Services and the challenges that the Secretary faces in that agency. We wel-

come you to the committee, Mr. Secretary, Mr. Administrator. Glad to have you.

Secretary THOMPSON. Thank you.

Senator LINCOLN. I look forward to a working relationship as we face some of these problems.

Just touching on what Senator Snowe was talking about, I notice that it sparked a great deal of interest in you in working towards better technology and this paperless system.

I would just reiterate the maps or the charts that Senator Conrad presented. In traveling in the last two breaks and visiting many of my rural hospitals, they are pretty much required to get to a very similar system of paperless operations in order to meet both the demands of the contractors, as well as the HIPAA, in some of the technology that they are having to put into their hospitals.

It is very difficult when they have absolutely no resources, as a rural hospital does, falling in that line in that category of, I think, a negative 2 percent.

So, I hope that we can work on that, and particularly pay attention to those hospitals that are striving to do that for other regulatory purposes, but also who are working at a disadvantage already in terms of the reimbursements. Because the reimbursements are low and because their percentages sometimes are at 60, 70 percent Medicare, they are really, really strapped. So, I hope we can work towards that.

Secretary THOMPSON. Thank you very much. I want to work with you on it.

Senator LINCOLN. Absolutely. I think that we can bring to the table not only some situations that these hospitals are going through, but also some ideas and solutions that they are looking for themselves right now to try to meet those terms.

You all had mentioned that your technology is somewhat antiquated, dating back to the 1970's. To accomplish some of the goals that, Mr. Secretary, you and Administrator Scully have set for the CMMS, such as replacing this outdated technology and expanding the educational campaign for beneficiaries, do you anticipate needing further financial resources?

Secretary THOMPSON. Senator Lincoln, we have $36 million in the President's budget for a new bookkeeping system called HIGLAS, which is really probably the most important thing right now for the Centers for Medicare and Medicaid Services.

We have got money set aside for new computer systems, and we are looking at a whole new initiative to modernize the computer system. But we are not asking for any extra money at this time for that. We will put together a budget initiative for the next fiscal year in regard to that.

Senator LINCOLN. And what is your time frame? I am sorry, I came to the hearing late. I may have missed that. But what is your time frame for really working to put that new technology into place?

Secretary THOMPSON. Well, the HIGLAS bookkeeping system has got to be done. The first phase of it is $36 million. We are expecting, hopefully, that Congress will approve that in the President's budget. We will get started on it as soon as it passes. We have al-

ready started the preliminary work towards that. We are already looking at a whole new IT system and we are reorganizing the department.

We are looking at setting up an IT division for the department so that it can purchase new computer systems for all of the divisions, so we can get down to one complete, modern, new system.

We spend millions of dollars in that department on new computer systems, and we have over 200 different computer systems. Nobody can talk to each other. It is the worst system I have ever encountered.

What we are trying to do, as is it is not efficient and it is not able to accomplish your objective or our objective, we would like to be able to get that down to one system so that we could have a computer system that Congress could plug into, that we could plug into, and that we could all communicate and deliver the services better.

So, instead of asking you for more resources, we are looking at a whole, complete, intense study of the whole department's needs to try and figure out if we have the resources internally. We spend all this other money. Maybe we would have the money if we had just bought a brand-new computer system. We may have enough money to give you some money back.

Senator LINCOLN. Well, I know that when I came in 1998 I acquired, or inherited, a very antiquated system myself. Finding out not only how much it was going to cost to update it, or better yet replace it, also the time involved, that is why I was interested to know that not only if you find the resources within, or certainly from the President's budget, being able to allow you to do that.

Secretary THOMPSON. We have 3,200 servers, 2,900 people to maintain 3,200 servers. We have 200 different computer systems. We have 85,000 workplace stations for 63,000 employees. You tell me if that is a system that works.

Senator LINCOLN. No. I am just hoping that, as you plan through replacing all of that, you also look at the time frame in which it is going to happen and that it does not take too long.

Secretary THOMPSON. It is going to take a while.

Senator LINCOLN. Well, hopefully not too long.

Secretary THOMPSON. But I am a pusher.

Senator LINCOLN. Good. Well, we appreciate that and we look forward to working with you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Secretary. A couple of points. One, I think you know that the Senators have a lot of very deep concern about these issues. Frankly, I think the passion, anxiety, and concern probably could have been voiced even stronger than it was by members of this committee.

But I think you essentially did not hear it because this was an opportunity for you to explain what you are doing at the department with CMS. But I do not want you to go away from here thinking, well, things are under control, we just have to keep moving along, because they are not.

Secretary THOMPSON. They are not.

The CHAIRMAN. It is a crisis. It is a real urgency here.

This leads me to a second point. Namely, we have just touched the tip of the iceberg here in this hearing. We have not even begun to get down deep into what has got to be done.

Secretary THOMPSON. I hope you call us back.

The CHAIRMAN. I definitely will. That is my next point, that we will have a subsequent hearing. But I want to give you the time to do what you need to do, because you are, after all, in charge.

I was serious when I mentioned that I would like you to send to the committee a letter of the administrative changes, the priorities, with deadlines and time lines, and then also a list of legislative requests that you think make sense, and priorities there as well.

I know from experience that you need to set deadlines. You need to set dates, deadlines, and benchmarks, otherwise things tend to slip.

I do not want this to be just another HCFA hearing where we all have the right motives and speak with great intentions, but because of the rush of business and things that happen, things slip a little bit and something else arises and pushes aside the efforts we are attempting to undertake.

So that is why we are going to have subsequent hearings, to take stock of how we are doing and what needs to be done. I want this committee to help you in finally solving this thing.

As I said, we have just begun to touch the tip of the iceberg. I did not begin to give you all the complaints that I hear. I did not do so, because I want you to solve them in advance. If you do not, you are going to hear them.

Secretary THOMPSON. Thank you.

The CHAIRMAN. Thank you very much.

Secretary THOMPSON. I want to thank you, Mr. Chairman, and all the Senators, for giving us this opportunity. I think that this has been the best hearing that I have been in front of since I have been here four and a half months ago.

I came out here to do a job. Tom Scully gave up a very lucrative profession to come in to help me, and I appreciate that very much. We want to change. We do not want to just change for change sake, we want to change so that it is better and more responsive, not only to you, but to your constituents and to all Americans.

The CHAIRMAN. Thank you very much. We appreciate your taking the time.

Our next panel consists of Mr. Bill Scanlon, Director of Health Care Issues for the General Accounting Office; Michael Gluck, who is a Ph.D. and professor at the Institute for Health Care Research and Policy at Georgetown; Dr. Judith Hibbard, Professor of Health Policy, Department of Planning, Public Policy, and Management at the University of Oregon; and Dr. Nick Wolter, who is the president and CEO of Deaconess Billings Clinic in Billings, MT.

Dr. Hibbard, I understand that you earlier had a time constraint. Do you still have that?

Dr. HIBBARD. I do, yes. I can stay a little bit beyond the time.

The CHAIRMAN. By what time do you have to leave?

Dr. HIBBARD. If I could leave by 10 after 12:00.

The CHAIRMAN. All right. Why don't you proceed first then? Then that will help us if we get into a bind here.

Dr. HIBBARD. Thank you.

STATEMENT OF DR. JUDITH HIBBARD, PROFESSOR OF HEALTH POLICY, DEPARTMENT OF PLANNING, PUBLIC POLICY, AND MANAGEMENT, UNIVERSITY OF OREGON, EUGENE, OR

Dr. HIBBARD. Chairman Baucus, Senator Grassley, and members of the committee, thank you for this opportunity to testify. I am Judith Hibbard. I am a professor of Health Policy at the University of Oregon.

I currently work with the National Quality Forum, where I provide expertise on how to effectively report health care information to consumers. I am pleased to be here today to testify about the information needs of Medicare beneficiaries.

In my research, I have investigated how consumers make choices and I have studied consumers of all ages, including Medicare beneficiaries. My current work is supported by CMMS, the Robert Wood Johnson Foundation, and the Public Policy Institute at AARP.

As you know, the Medicare program works best when beneficiaries make informed choices. Recent changes have expanded those choices and the amount of information that beneficiaries receive.

My research has focused on how beneficiaries are faring under this new condition. As Mr. Scully indicated, what we have found too is that there are serious deficits in what beneficiaries know about their choices.

Of greater concern is our recent finding that more than half of the beneficiaries population has difficulty understanding the comparative information about Medicare options.

When asked to review comparative tables and charts showing plan characteristics, a majority of beneficiaries had difficulty accurately interpreting that information. Compared to the under-65 population, older beneficiaries make about three times as many errors in looking at simple charts and tables with the same information.

So those beneficiaries who have the most difficulty also felt that having choices, many choices and lots of information, was a burden. They preferred to have someone else make a choice for them.

What beneficiaries need to be able to do to make an informed choice is formidable. They need to understand the information and to be able to differentially weight cost factors, quality, and benefit factors to match their individual needs.

These kinds of tasks are difficult for most people, and they are particularly difficult for the elderly. So helping beneficiaries use information and apply it to their own situation it the type of assistance that is most urgently needed.

This means providing help that goes beyond information dissemination to providing some decision support. Decision support can be provided via group counseling, over the telephone, or through computer-aided decision tools, but most beneficiaries prefer to have assistance in a one-to-one counseling with a live person.

The most effective approach to communicating with beneficiaries will have to take into account the tremendous differences within the beneficiary population in their ability to comprehend and use information and choices.

This means tailoring education to the different segments and to their ability levels. Making the choice test easier for beneficiaries would also help. This could be accomplished by having fewer types of plan designs to choose from, and less complexity associated with each of those choices.

Three final recommendations. First, the National Medicare Education program requires adequate resources. The complexity of the options and the diverse abilities in the Medicare population make beneficiary education a very challenging task.

Because beneficiaries still lack the understanding of their choices, it is premature to implement the lock-in feature of the Medicare+Choice program scheduled to be implemented in 2002.

Finally, providing information does not equal understanding. Beneficiaries have been provided with information but they still do not understand. It will be very important for the new Centers for Medicare and Medicaid Services to assess beneficiary knowledge levels on an ongoing basis to determine the degree to which their educational efforts are actually successful.

I was very pleased to hear Secretary Thompson's announcement that beneficiary education is going to be a higher priority. This is an important step.

The centers' challenge is to improve communications to beneficiaries by tailoring information to the diverse needs in the population and to find ways to provide assistance to beneficiaries that moves beyond information dissemination to education and decision support.

Thank you for this opportunity to testify today. I am happy to answer any questions.

[The prepared statement of Dr. Hibbard appears in the appendix.]

Senator GRASSLEY. Thank you, Dr. Hibbard.

What we will do is go through the panel, then because you have to go by 10 after 12:00, we will ask you questions first.

Dr. Scanlon?

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEATLH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Senator Grassley, Senator Breaux, and Senator Lincoln.

I am very pleased to be here as you discuss the ability of CMS, or HCFA, to carry out its mission to manage the Medicare program both now and in the future.

It was very heartening to hear the consensus about the challenges, as well as some of the initial steps in terms of trying to meet those challenges that HCFA faces. However, of course, we need to focus very much on the details in order to be able to find effective solutions.

Medicare will always pose an enormous management challenge regardless of who runs it. Any agency that manages a $220 billion program and must respond to the vast and varied universe of health care providers, beneficiaries, and taxpayers will be the target of parties that feel disadvantaged or harmed by some of its decisions.

Nevertheless, it is possible to take stock of HCFA's past experience and determine what lessons they hold for CMS in the future.

Tasked with administering the extremely complex Medicare program, HCFA earns mixed reviews. On the one hand, the agency presides over a program that is very popular with beneficiaries and the general public. It has implemented payment methods that have helped constrain program cost growth, and each year pays almost 900 million claims quickly with very small administrative budgets.

On the other hand, HCFA has difficulty making refinements to payment methods, such as the calibration for urban/rural differences that Senator Conrad was talking about. It has also fallen short in its efforts to minimize inappropriate claims payment and ensure the quality of Medicare services.

In recent years, HCFA has taken steps to achieve greater success in these areas. However, the agency now faces criticism for imposing payment safeguards that many providers feel constitute an undue administrative burden.

As we look at HCFA's record for managing Medicare, we note that major gaps exist between the agency's capabilities and expectations for what it should be doing.

First, we and others believe—and that includes Secretary Thompson—that HCFA may have too many things on its plate. In addition to Medicare, HCFA must oversee 50-plus Medicaid and 50-plus State's Children's Health Insurance Programs, compliance with HIPAA standards by insurance plans in several States, and quality inspections of nursing homes, home health agencies, clinical laboratories, and other providers. To manage all this work, the agency has a total of 49 senior executives.

Moreover, as Senator Breaux indicated, HCFA has a real problem in terms of continuity of leadership. In 24 years since its inception, there have been 21 administrators or acting administrators. Such short tenures and frequent leadership shifts have not been conducive to developing or carrying out strategic plans or long-term innovations.

HCFA's capacity is strained compared to its multiple complex responsibilities. Human capital and information system deficiencies, coupled with constraints on its flexibility, hinder the agency's performance.

Staff shortages, in terms of skills and numbers, beset HCFA. These shortages were brought into sharp focus as the agency struggled to handle the many changes in the Balanced Budget Act, such as expanding Medicare's managed care options. Few staff had experience in dealing with existing health maintenance organizations, let alone the new entities that the Act introduced.

Conducting a nationwide information campaign to assist beneficiaries in making plan choices involved marketing and communication expertise not previously needed.

Staffing constraints have also meant that important tasks well within the agency's capabilities are just not done with sufficient frequency. For example, HCFA's oversight of State inspection activities is essential to ensuring quality of care.

Yet, in 1999 the number of Federal reviews of State nursing home inspections averaged about two per state, a number totally inadequate to fairly assess how well any State is doing.

In a program with such a large number of beneficiaries, providers, health plans, and the vast number of claims being paid, a modern information system is an essential foundation to effective management.

Indeed, when we look at how Medicare and private insurance have diverged over the past 30 years, an element that stands out is how some insurers have attempted to use information to become effective, prudent purchasers.

Regrettably, Medicare is not in a similar position. HCFA's information systems are antiquated and inadequate. Implementing program changes such as those in the BBRA or the BBA is a time-consuming and arduous task, draining scarce resources from other activities.

Even more importantly, the systems do not provide the information needed to effectively manage the program. As the array of BBA changes was implemented and calls were made for modifications, HCFA had great difficulty in providing the Congress solid information on the actual impact of these changes on beneficiaries and providers. That type of information is what should guide formulation and refinement of policy.

Finally, HCFA's performance is also hindered by a lack of flexibility. As a public program of such great magnitude, we would not expect or want Medicare to have as much flexibility as private organizations. However, we need to find the right balance between flexibility and accountability so that Medicare can be managed as effectively and efficiently as possible.

How Medicare contracts with companies to process claims is a great example. Rules enacted in 1965 limit who contractors can be, what tasks they do, and how they are paid, all constraints that effect how well HCFA can ensure contractors' activities are performed satisfactorily.

With the growth and transformation of the health care industry, there are expectations that an agency running the Nation's largest health insurer will act as a prudent purchaser and will carry out customer relations effectively. There are also expectations that the agency will be prepared to implement restructuring and add benefits in the context of Medicare reform.

Today's Medicare agency, while successful in certain areas, may not be able to meet those expectations effectively without further Congressional attention to its multiple missions, capacity, and flexibility.

The agency will also need to do its part by planning strategically. That is, setting priorities, documenting resource needs, and holding managers accountable for accomplishing program goals. This has not been its strong suit in the past, yet these tasks are critical to successfully dealing with the challenges of the future.

Thank you very much, Senator Grassley. I would be happy to answer any questions you or members of the committee may have.

Senator GRASSLEY. Thank you.

[The prepared statement of Dr. Scanlon appears in the appendix.]

Senator GRASSLEY. Now, Dr. Gluck?

STATEMENT OF MICHAEL GLUCK, PH.D., RESEARCH ASSOCIATE PROFESSOR, INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Dr. GLUCK. Senator Grassley, Senator Breaux, Senator Lincoln, my name is Michael Gluck, and I am happy to be here today as you consider the management and governance of the Medicare program.

As a faculty member at Georgetown University's Institute for Health Care Research and Policy, I am engaged in research on this very topic, funded by the Public Policy Institute of AARP.

In addition to synthesizing existing data and literature, my colleagues and I have conducted 40 structured interviews with experts who have hands-on experience in the management of CMS activities. They include providers, beneficiary representatives, current and former career employees, and political appointees from both parties.

Prior to coming to Georgetown, I directed a large project on Medicare reform at the nonpartisan National Academy of Social Insurance, where we also considered issues of Medicare management.

My testimony today is drawn from work at both Georgetown and at NASI, but I speak only for myself and not for any organization.

In my statement I would like to focus on the important challenges facing HCFA, now known as CMS. These are staffing, information technology, the agency's administrative budget, and beneficiary and provider services. My written testimony discusses additional issues.

There is a clear need for more staff with experience in modern private health insurance industry. The agency now has little capacity to attract and retain such individuals.

There is a perception among many outside of CMS that the agency has a conscious or unconscious bias against managed care in favor of the traditional fee-for-service program.

Our analysis suggests that the problem is actually a general lack of in-house experience with how health insurance plans go about their business, whether they are fee-for-service or HMOs. Our analysis also indicates difficulties in maintaining sufficient expertise in the areas of medicine and information technology.

The limiting factor appears to be the agency's salary structure. Among the options Congress may want to consider are adjustments and supplements to CMS's compensation structure sufficient to attract individuals from the private sector. Other parts of the Federal Government have some flexibility to pay more to maintain a skilled workforce.

As we have heard this morning, computers are essential for paying Medicare providers. They also have great potential in improving quality and in helping beneficiaries negotiate Medicare's complexity. However, the program's computer technology is antiquated.

To its credit, Medicare does have a strategic plan for its information technology, but we found nearly universal agreement that Medicare needs significant new investment in this area.

Our interviews also suggested lessons from the failed Medicare Transaction System (MTS) of the 1990's that may help as the agency addresses these issues.

Chief among these is that changes should be made in discrete pieces and staggered over time to allow the agency to learn as it goes. One interesting idea that emerged from our work, is that CMS might commission several prototype systems before settling on a single contractor, much as the Department of Defense does when procuring a new jet fighter.

Our work suggests that the strain on Medicare's administrative budget has hit provider and beneficiary services particularly hard. Funds for provider education this year are half of what they were in 1995.

The vast majority of providers want to bill Medicare correctly, but they need help in understanding the complexity of the rules. At a time when Congress has made the elimination of improper Medicare payments a priority, such education is vital. Funds for contractors to answer beneficiary inquiries are also very limited.

CMS itself has come a long way since 1997 in developing written materials explaining Medicare and the choices available to beneficiaries, but it still has a long way to go.

The next step is for Medicare to develop better ways to help individual beneficiaries with their own particular needs. The toll-free telephone line is largely focused on specific health plans available to beneficiaries. In an effort to assure that beneficiaries receive correct information, the telephone agents work only from scripts.

The State Health Insurance Programs also appear to be underfunded and vary greatly across the country. Some have suggested that CMS itself should have a local presence, such as one employee in each Social Security office. Others suggested that the Internet and modern telecommunications would allow Medicare to provide the same individualized service in a more cost-effective manner.

Our initial analysis suggests that the right course of action is not obvious, and we will be conducting a more detailed analysis on this, and other issues, in the coming months.

I am happy to answer your questions, and thank you for the opportunity to be here.

The CHAIRMAN. Well, thank you very much, Dr. Gluck. I apologize for not being able to hear you testimony. But thank you very much for testifying. We certainly have your statement for the record.

[The prepared statement of Dr. Gluck appears in the appendix.]

The CHAIRMAN. Now I would like to introduce our next panelist who is from Montana. Dr. Nick Wolter is a practicing physician. He is also the CEO of the largest hospital in the State of Montana, and he serves on the board of the Montana Hospital Association. I have known Nick for years.

I might say to my colleagues that he is one of the most thoughtful, wisest, and most caring, bright persons I have ever had the privilege to know. He is a great asset to Montana, to the hospital community, to the State, and to patients. It is an honor for all of us to have him here.

I just want to thank you, Nick, for coming to talk to us.

I also want to thank Jim Duncan, sitting behind him. Jim is also associated with Deaconness Hospital in Billings and has done a tremendous job for that community. And Kathy Kenyon, the gen-

eral counsel of Deaconness, is also here with us. We thank you very much, and thank you for taking the time.

STATEMENT OF DR. NICK WOLTER, PRESIDENT/CEO, DEACONNESS BILLINGS CLINIC, BILLINGS, MT

Dr. WOLTER. Well, thank you, Senator Baucus. Of course, we thank you for all the help you have given us over the years on health care issues. It is a pleasure for me to hear the vantage point of the other committee members, and actually gives me a little optimism to hear some of the issues that have already been expressed.

I would just quickly say that Deaconness Billings Clinic, in addition to a hospital, includes a very large group practice of about 170 physicians. We manage very small rural hospitals, including critical access hospitals. We have a nursing home. We are a sponsor of a health plan. So, we are involved in really all aspects of health care delivery.

I think, if there is one message I bring that is very loud and clear from the physicians, the nurses, the pharmacists, the respiratory therapists that I work with, it is that the regulation, the ambiguity, the amount of paperwork has become so overwhelming that it truly is draining away the time and attention that providers have for patients. I think this has become obvious to the patients themselves as well.

Now, as an executive from an organizational standpoint, I will also tell you that the cost of complying with these regulations and ambiguities is very, very high.

We at Deaconess Billings Clinic, for example, employ 12 coders who do nothing but support the difficult coding requirements for Medicare. The cost of their salaries and benefits, plus other consultation and expertise that we bring in annually, is a half a million dollars per year. Surely these funds could be spent in other ways.

I would like to tell you one story, too, from my testimony. This concerns a 60-year-old gentleman who presented to the hospital in Sidney, Montana, which is about 250 miles away from Billings.

The CHAIRMAN. By air.

Dr. WOLTER. He was having chest pain. He presented up in Sidney. I think he was brought in by his family. His initial studies showed that he was having an acute myocardial infarction, and his treating physician made the decision to transport him by air to Billings, Montana to Deaconess Billings Clinic, which was done. Upon arrival, he had further studies, a cardiac catheterization, and ultimately underwent coronary bypass surgery.

The air ambulance claims submitted to Medicare have subsequently been denied because it is the judgment of RFI that this transport was not medically necessary.

This particular story illustrates a number of issues with the program that have been bothering us. First of all, we now have had 110 denials over the last 5 or 6 months, which are about similar cases. This represents about $500,000 in reimbursement to us, and this to a program that we already subsidize by $1 million a year.

It illustrates the inconsistency from one region to another. We understand that in other regions this very narrow interpretation of medical necessity is not occurring.

We find that the dispute resolution process is very, very frustrating. The administrative law judge process is expensive, it is unwieldy, and rarely, if ever, does it result in new policy making. We find there is no one to go to who will take accountability for helping us to resolve this issue.

I think, most importantly, it goes to the heart of quality of care, however. If patients who are in immediate need of urgent care are not going to be supported by the Medicare program, this is obviously very frustrating to a physician.

I will tell you, as a physician who as an intensive care unit doctor has supervised many flights like this, it would be malpractice for us not to transport a patient with these circumstances. Yet, we find ourselves in a very cumbersome process of denials around medical necessity.

We certainly hope that some of what we heard from Secretary Thompson today will begin to address accountability and timeliness of response in a different way than we have experienced in recent years.

The last thing I would like to emphasize, as Senator Breaux said, is where do you start with some of the issues in a program like this? There are so many things we could say. But the rural issues are very significant. Montana, like Arkansas, like North Dakota, like Iowa, is a very rural State.

So many parts of the Medicare program have built-in geographic adjustments that do not pay rural providers, whether it be hospitals or physicians, in the same way that there is payment in other parts of the country.

The ability to invest in infrastructure, technology, recruit and retain nurses and physicians, is much more challenging in rural States, much less the ability to come up with the resources to deal with the new regulations, HIPAA, and many of the other new things that are coming our way. We would strongly support an approach to looking at these rural inequities.

My testimony includes a number of other recommendations. Secretary Thompson did ask that we try to provide solutions, not just complaints, and we look forward to working with the committee, with the newly-named organization, and with anyone who would invite us to participate in solutions for the future.

Thank you very much.

The CHAIRMAN. Thank you very much, Doctor.

[The prepared statement of Dr. Wolter appears in the appendix.]

The CHAIRMAN. Dr. Hibbard, if you have a time constraint, you may be excused.

Senator BREAUX. May I ask her one question?

The CHAIRMAN. Sure. Do you have a couple of minutes, Doctor?

Dr. HIBBARD. Yes.

The CHAIRMAN. Thank you.

Senator BREAUX. On the question of information, there are some who would argue that Medicare beneficiaries are not capable of making informed choices, therefore you need to stay in the traditional fee-for-service program.

If you give them choices in the private sector that they have to make, that they are really not capable—I am sort of summarizing—of making these informed choices.

Do you have a comment on that?

Dr. HIBBARD. I think what we found in our research is that there is really quite an array of abilities to use information in decision making. So there are maybe about half of the Medicare beneficiaries that have the skills to comprehend the information, to use it in choice, but there is also a significant portion who have difficulty. So, any program to educate and to help is really going to need to take into consideration this diversity in people's ability and provide help.

Senator BREAUX. It seems to me they make an awful lot of choices now. In traditional fee-for-service, a Medicare beneficiary has to pick the doctor they are going to go to, or the hospital they want to go to.

They either make that decision unilaterally if they are capable, or they have their children or grandchildren help them, or a senior center help them in making those choices.

I am not sure that there is going to be a great deal of difference giving them other choices in the private sector that they may want to have to make and decide which is the best place to go from what they have already. It seems like they make an awful lot of choices now under the current fee-for-service system.

Dr. HIBBARD. Yes, people do make a lot of choices now. They may not be the best-informed choices. But those who do have this difficulty really find having a lot of choices and a lot of information a problem and a burden. They do not want that responsibility.

The CHAIRMAN. Thank you, Senator. I think she has to leave pretty quickly. I think it will give us a chance to ask a couple of questions.

One question I have, Dr. Hibbard, is this. Social Security used to administer Medicare, but it became a secondary issue for Social Security offices around the country, so they withdrew. We do not have Medicare offices around the country like we have Social Security offices around the country.

Can the consumer education aspect of this be solved, by and large, without having Medicare offices all around the country as we do now with Social Security offices? I think Social Security is a better-accepted program because people can go into the Social Security office and have some comfort, person-to-person. But that is not true with Medicare.

Dr. HIBBARD. Yes. It would definitely help to have a person, for example, in a Social Security office that is trained to deal with Medicare. This is what beneficiaries want. They want access to a real person to talk to and to help them through the issues. I think that would be a tremendous help.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Dr. Hibbard, in your research about the ways that beneficiaries get access to their information, what observations, if any, have you made in regard to seniors in rural areas?

Dr. HIBBARD. Well, coming from a rural State, I am familiar with some of the issues for beneficiaries. The example of the Social Secu-

rity office is a good one because that is something that people know where to go. But in rural areas there are just less resources, but the issues and the problems are still the same.

Senator LINCOLN. But getting that information poses an even greater challenge out there, as you said, without a Medicare office or a Medicare-trained individual in that Social Security office giving that information to them.

Dr. HIBBARD. Right. And when you look at, like the SCHIP offices, in big cities they have a lot more resources, and as you get further out there is less and less out there for beneficiaries to help them.

Senator LINCOLN. Thank you.

The CHAIRMAN. Thank you, Dr. Hibbard.

Dr. HIBBARD. Thank you.

The CHAIRMAN. Thanks for taking time.

Dr. Wolter, I wonder if you could address some of the regional variations in administration of Medicare programs. That is, we are told that different regional offices interpret some of these regulations a little bit differently and it makes it quite confusing for health care providers. Is that the case or not?

Dr. WOLTER. Well, we certainly have found several instances where major inconsistencies in interpretation have occurred. The most dramatic, is the case that I just cited in terms of looking at the criteria for necessity of medical air transport.

When these occur, finding a way to get some resolution and some way of looking at it more nationally so there is more consistency is very, very difficult.

The CHAIRMAN. What does this all come down to?

Should there be a separate agency as there is with Social Security Administration, a single administrator, a separate budget to Congress, a more specific focus than an agency under HHS, or is it a whole new system we need in providing health care benefits?

If you were Mr. Scully or Mr. Thompson and you could wave the magic wand and Congress and the President would do whatever you wanted them to do what would you do?

Dr. WOLTER. I do not know if you remember this, Senator Baucus. But 8 or 10 years ago I was in my scrubs in the intensive care unit at Deaconess Hospital and you walked in, you sat down next to me, and you said, well, what should we do about health care? I am not sure I came up with a very good answer that day.

I think the question you just asked me is obviously one that this committee has been wrestling with for a number of years. I heard about the number of days of testimony you had last year with nothing written coming out of that. I think the complexity of the situation is one that has people wondering if, indeed, we can find a way to move forward.

But I go back to what I think I heard Senator Breaux say in his introductory comments. There are significant improvements that are on the table that we can begin to start addressing, and that is the best answer I can give you, is let us start. There are a number of things we can do better.

Let us start with those, one by one. We have some new energy in the department. I think that is the place to start. Will events over the next two or 3 years precipitate a more major way of look-

ing at what kind of changes might be necessary? That is certainly possible.

The CHAIRMAN. One thought that has occurred to me, and I think it was the Secretary who was talking about a paperless administration network, was how much would that really solve the problem. Under the current system, data still has to be entered. Even if you have a computer system, somebody still has to enter the data.

One of the reasons that things are so complex, it seems to me, is we have so many different health care systems with different needs and different requests. I mean, there is Medicare, there are all the private managed care companies, there is Tricare, there is the VA system. They are all trying to provide health care, but they are all a little different.

Maybe some effort has to be undertaken to standardize some of the different components so there is not so much complexity and overlap between different carries, different providers, and different insurance companies, all with different ways of doing things.

A lot of it, too, is the litigious nature of our society. That is, people ask for more data to protect themselves in case there is a lawsuit filed.

I do not know that a paperless society is going to solve these problems. Your thoughts?

Dr. WOLTER. Well, I would agree with Secretary Thompson that health care is behind other industries in the application of technology in much of what we do. But I would also agree with Senator Kerry, that when you look at the technology we have and apply it to individual patient care, we are doing some wonderful things.

But in terms of claims administration, information gathering and collection, making sure that data is available to caregivers at the time that they need to give care, there are many, many improvements I think that technology will be bringing us over the next 5 or 10 years.

I think that technology works, however, only when the processes that it is supporting are also streamlined. I think that is the challenge for Secretary Thompson.

The CHAIRMAN. Now that you have listened to Secretary Thompson, did he say anything that you would like to respond to?

Dr. WOLTER. Well, one thing I was quite pleased to hear is looking at the contractors and trying to standardize how they are selected and what kind of criteria are used in looking at best practices. I think that may help us address some of these consistency issues.

The CHAIRMAN. All right. Thank you very much. My time has expired.

Senator Grassley?

Senator GRASSLEY. I am going to start with Dr. Scanlon. You have had an opportunity to hear both Dr. Hibbard and Secretary Thompson talk about the need for beneficiary education. I think it is very urgent, but I think we also need to establish some priorities, given the fact that there is $35 million for that purpose.

That may sound like a lot of money, and the Secretary is committed to it. But what would you see as the most pressing needs if you were going to have some priorities? Or even if you would

only list one, the important things is, what do you think that $35 million ought to be spent on?

Dr. SCANLON. I think, given that in the past several years we have provided Medicare beneficiaries with a handbook providing a comprehensive picture of their benefits that can serve as the reference work, that what we need to focus on in the coming year is the issue of choice. Beneficiaries do have a set of choices to make in terms of enrollment in plans. They need very clear information about what those choices are, and they need some basis for making a choice among plans.

This is an area, I believe, in terms of Dr. Hibbard's work, where we need effective communication on how plans differ in terms of what they are offering, and the quality that they are offering to beneficiaries. Those are key in terms of an information campaign.

The second thing, if you will give me a second thing, I think we do need to take advantage of technology. We do need to have the 1–800 number working extremely effectively in terms of being able to respond to beneficiaries' inquiries. We need to publicize its availability well enough so that beneficiaries are very aware of it.

We do also need to make sure that, in using the Internet—although I have some concerns about the fact that only a certain segment of the beneficiary population have access to the Internet—we are using it effectively in terms of putting information out there that is very comprehensible and understandable for those that are using it.

Senator GRASSLEY. Dr. Gluck, and then maybe Dr. Scanlon would like to comment. You made a number of helpful points about the CMMS' need in the areas of personnel and information technology. More flexibility in these areas seems to be critical to CMMS being able to adapt to change.

You did not mention the civil service laws to which CMMS is subject. The reason I bring that up, is because in 1996 the Social Security Administration was taken out of Health and Human Services and increased personnel flexibility was given to the new agency.

I would like to hear from you and Dr. Scanlon on whether similar flexibility would help the agency prepare for changes that it would have to do for the future.

Dr. GLUCK. We have not come to any conclusion about whether breaking the agency out of the department is a net plus or not. In the interviews that we did, I think the old adage of where you sit, or in this case where you sat, tells you a lot about where you stand. People who were in the agency talked a lot about the additional burdens that were placed on it by having to go through departmental processes.

People in the department saw the current structure as a good opportunity to make sure that there was consistency with administration policy, and to be able to give a broad overview of what went on in the agency. Our analysis is ongoing.

Senator GRASSLEY. Personnel flexibility.

Dr. GLUCK. On the issue of personnel flexibility, what came through was a clear need to be able to attract what we referred to as the best and the brightest from the world of modern health care insurance management. The agency cannot do it.

You mentioned the example of Social Security. In the Public Health Service they have the capacity to pay senior scientists—and physicians as well—at a level that is sufficient to attract the folks that they need to carry out their business. At a very minimum, I think that is a worthy area to look at.

Senator GRASSLEY. Anything to add, Dr. Scanlon?

Dr. SCANLON. Well, Senator, I would concur. I think the precedent for granting this kind of flexibility has been when the private sector competition is too great and it is impossible for government to recruit an adequate number of the types of individuals that it needs, that there has been some flexibility granted.

HCFA currently has some flexibility in terms of information technology personnel. But, as we have indicated, both Dr. Gluck and myself, today, in the area of private insurance there is also a need for expertise within HCFA, and that they have had difficulty over time in terms of trying to recruit people in that area.

I think it is very important that the agency come to the Congress with very specific plans as to what authority is needed and how it would be used to be able to guide your decision in this area.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. That was very helpful. Thank you, Dr. Scanlon.

Senator Breaux?

Senator BREAUX. Dr. Scanlon, thank you for the usual good job that you do in the health areas on behalf of GAO.

You mentioned one of the things in your testimony, when over looking at HCFA and HHS, that estimates by the HHS Inspector General of payments made in error amounted to $11 billion last year.

Dr. SCANLON. That is correct, Senator.

Senator BREAUX. Now, tell me a little bit about how you think the HHS Inspector General goes about finding $11 billion in error in terms of payments that are made. If, in effect, they have made a determination that $11 billion of payments were made in error, why were they made?

Why was the Inspector General not up there looking at all of this and saying, no, this should not be done, yes, this can be done? Why did they find this out after the fact?

And this is not just last year. The previous year, too. This is all consistent over 10 years, and probably averages $110 billion in payments in error. We could do an awful lot in 10 years if we had $111 billion. You could go a long way to getting a decent prescription drug program implemented.

But the question is, if we can determine that these payments were made in error, why can we not determine that they should not be made?

Dr. SCANLON. The problem is that the resource intensity required to be able to identify that the payments were made in error is so large, that we could not afford to do it for all the claims that are processed in the system.

As I indicated, there are about 900 million claims processed every year. Most of them are processed electronically. They are never, in some respects, touched by human hands.

They are reviewed for certain consistencies in terms of diagnosis and procedure, whether the beneficiary has used certain services in the past, and if all those consistencies check out, the claim is paid.

In terms of the Inspector General's review, what is different is that they go to the provider and ask for documentation, the medical record, for this particular beneficiary, for this particular service.

In looking at the details within that medical record, they are able to make a much more sound judgment as to whether or not this was a medically necessary service.

Now, a portion of those claims that the Inspector General says were inappropriately paid are because the providers never sent in the documentation, so there was nothing to review. The presumption is that, if the provider does not provide documentation, then it was an inappropriate payment.

Senator BREAUX. So it is easier to define the error than it is to prevent the error.

Dr. SCANLON. Well, we also need to remember that the Inspector General only works with a very small sample of claims and makes an extrapolation to estimate that there are $11 billion in inappropriate payments. So, it was not easy for them to identify the inappropriate payments that they did. In fact, it was a very resource-intensive activity.

Senator BREAUX. If you run across, in your review, a situation whereby Medicare does not proceed against companies that they have already paid the Medicare payment to, an insurance company issue where a Medicare person may have had their bills paid by a third party insurance company that Medicare pays also—I am thinking of the example of a Medicare beneficiaries who is hit by a car that has insurance coverage.

That patient is picked up, taken to the hospital, and presumably Medicare would pay the hospital and medical charges for that patient. But there is a third party responsible which has liability coverage, which I understand is not pursued against very much on the part of Medicare. Have you ever run across that?

Dr. SCANLON. We have. One of the responsibilities of the Medicare contractors is to identify when Medicare should be what is known as a secondary payor and to allow some other third party, an insurance company, workman's compensation program, or whatever to be the primary payor and to pay the bill.

The issue is that there has been variable performance on the part of contractors in being able to identify claims that should be paid by another payor and where Medicare should be the secondary payor. It is an area where there needs to be improvement.

It is also an area where, again, we have a challenge because it is hard sometimes to identify the information that you need to know that there is another primary payor involved. It involves putting a burden on providers or it involves putting a burden on beneficiaries, sometimes, to get that information. It is a concern we have had.

Senator BREAUX. I have had people tell me that if Medicare just contracted out the pursuit of those secondary payors, that it would be a very worthwhile endeavor. I mean, there are literally hun-

dreds of millions of dollars that should be the responsibility of a third party payor that Medicare is not pursuing.

Dr. SCANLON. Well, I think in the context of thinking about contractor reform, one of the issues is how you could specialize certain functions that contractors do today, and whether or not you can gain efficiencies from such specialization.

Right now, in the Medicare integrity program, with the authority that you have given HCFA to have program safeguard contractors, there are experiments, in some respects, under way. There are approximately a dozen contractors who have contracts with HCFA to do different safeguard functions, and pursue these different types of activities in different ways so that we can learn what is most effective. We may come to the conclusion, secondary payer activity is a function that is best to contract out separately.

Senator BREAUX. Do you think that would be a positive endeavor?

Dr. SCANLON. It is possibly a positive endeavor. First of all, we have a contractor now that is doing the function for us. The question is, do we need a specialized contractor who focuses on this? If we do, under what terms should that contractor operate?

The CHAIRMAN. Thank you very much, all of you. This has been a good first step, but there are many more to go. Thank you for taking the time.

The hearing is adjourned.

[Whereupon, at 12:25 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Hon. Max Baucus

Good morning. The Committee will come to order.

This hearing gives us an opportunity to shift gears. I'm not talking about shifting from a Republican to a Democratic majority. Sure, that's happened. And it makes a difference. But, by and large, we have to work together, on a bipartisan basis, if we're going to get anything done. That's as true now as it was last month. So I hope to continue the bipartisan approach begun by Senator Grassley. Instead, I'm taking about shifting gears in the focus of our work. Up until now, we've been focused pretty much on the big tax bill. That's behind us now.

But another issue, that's just as important, lies ahead. Reforming Medicare. Virtually every member of Congress has said that we should reform Medicare to cover payments for prescription drugs. So has the President. In fact, many of us have been saying this for years. In this Committee alone, we've had 15 hearings. The time for talk has passed. It's time to act. For these reasons, both Senator Grassley and I are committed to reporting a bill, by the August recess, that reforms Medicare to cover prescription drugs. That's an ambitious schedule. But I think it can be met.

Now, some people will say that we have to do more than provide prescription drug coverage. We should, they say, reform other parts of the Medicare program. I agree. We need to bring Medicare up to date. We need more competition. We need to give seniors more choices. Perhaps more than anything else, we need to need to make the program run better.

That brings me to the subject of today's hearing. I know that HCFA, or CMS as it's now called, has a lot on its plate. I also know that it's underfunded. Over the years, Congress has been asking HCFA to do more and more without a corresponding increase in resources. But it seems to me that the problems really come down to a few main ones.

The most important is how the agency communicates with the people and organizations affected by its decisions. Time and time again, I hear complaints, from both beneficiaries and providers. They complain about bad customer service, and about confusing rules and regulations.

Another big problem is personnel. Now, I don't mean to imply that HCFA lacks dedicated employees. It has plenty. Rather, the agency lacks some of the necessary skills. For example, few of its employees have experience in the private sector. They may not have experience overseeing private health plan options, which they are now asked to do.

I'm also concerned about information technology. At a time when we have become so reliant on technology, I hear again and again that HCFA's technology is outdated and inadequate.

Finally, I'm interested in hearing more about HCFA's ability to oversee its contractors. I'm glad to hear that the Administration is focusing on making HCFA, or CMS more responsive.

I'm interested in hearing about the changes the Administration plans to make under current law. And I'm interested in hearing what further changes should be made legislatively, either as part of a prescription drug bill or otherwise.

I look forward to hearing from our witnesses.

PREPARED STATEMENT OF MICHAEL E. GLUCK, PH.D.

Chairman Baucus, Senator Grassley, and members of the committee, my name is Michael E. Gluck, and I am happy to be here today as you consider the management and governance of the Medicare program.

Since last fall I have been on the faculty at Georgetown University's Institute for Health Care Research and Policy. For the five previous years, I was Director of Health Policy Studies at the nonpartisan National Academy of Social Insurance (NASI) where I headed up staff work for a large project examining Medicare's long-term future, including an on-going study of the program's administration. Since coming to Georgetown, my colleague Richard Sorian and I have continued work in this area with funding from the Public Policy Institute of AARP. We will be writing over the next several months about the challenges and potential remedies for Medicare administration. As part of both projects, I have engaged in structured conversations with over 50 individuals who have hands-on experience with the Health Care Financing Administration, now to be known as the Centers for Medicare and Medicaid Services (CMS). They include providers, beneficiary representatives, political appointees at the agency from both parties, current and former career employees, and others. I am happy to be here today to share with you some of what I have learned from my work at both NASI and Georgetown. In my testimony, I speak only for myself and not for NASI, AARP, or any other organization.

I would like to begin this morning by suggesting two general themes that I believe characterize CMS at this time, and I will then move on to what I see as the most important challenges the agency faces and some ideas for addressing them.

As someone who has been a student of Medicare policy with particular interest in the program's benefits and financing, the sheer enormity of the program's administration is most impressive. CMS must carry out an extraordinarily large number of diverse an complicated operational tasks. In general these include:

- management of contracts to pay claims for traditional (fee-for-service) Medicare
- management of Medicare+Choice contracts
- assuring adequate beneficiary information and services
- safeguarding program integrity
- making national coverage decisions
- implementing payment rates and procedures
- overseeing the survey and certification of health care facilities and other quality assurance activities
- setting standards and writing regulations to carry out many of these functions
- overseeing demonstrations and research to improve the program, plan for future financing, and to understand Medicare's role in the overall health care system

In addition to Medicare, CMS also has responsibilities for Medicaid, the State Children's Health Insurance program (SCHIP), and parts of the Health Insurance Portability and Accountability Act (HIPAA). Even though CMS contracts with other organizations to carry out many of these activities, it must still coordinate, oversee, and assure consistency among these contractors. Often CMS can only indirectly manage contractors' work even though it is ultimately accountable to Congress, beneficiaries, providers, and other taxpayers for how well these contractors do their jobs. Over time, CMS's responsibilities have grown with the adoption of prospective payment, the growing complexity of medical practice, and the growth of Medicare managed care. Even though Medicare's administrative budget has not grown to match these new challenges, beneficiaries get the health care they need and providers generally are paid accurately and on time. I will return to the issue of CMS's budget later in this testimony.

Another important theme to emerge from our work is that CMS has multiple goals and that these can conflict with one another. In general these goals are:

- protecting beneficiaries (i.e. assuring access to and quality of health care)
- protecting providers and suppliers (i.e. assuring timely payment for services provided)
- protecting the taxpayer (i.e. assuring the Medicare trust funds are appropriately spent)

The potential conflicts among these goals have increased as Medicare and health care have become more complex. For example, regulations to protect patient rights in Medicare+Choice plans impose some costs and burdens on health plans and providers. So too do data requirements for risk adjustment designed to assure that plans are paid properly and that beneficiaries have access to them. Similarly, efforts to eliminate waste, fraud, and abuse (i.e. protecting the taxpayer) can impose burdens on other providers. Tradeoffs among these goals are an inherent feature of the Medicare program and CMS's mission and will create inevitable tensions for CMS as it works its various constituencies.

I would now like to turn to the most important challenges facing CMS staffing, information technology, Medicare's administrative budget, provider and beneficiary services, and contractor reform.

Staffing

According to the experienced CMS-watchers whom we interviewed, staffing and information technology are the agency's most pressing needs. These are also perhaps the most amenable to intervention.

In the case of staffing, the experts with whom we spoke saw the problem to be more about the backgrounds and experience of current CMS employees than their actual numbers. CMS had 4219 full time equivalent employees in FY 1999, up somewhat from 3,979 two years earlier.[1] However, the agency has little capacity to attract individuals with experience in private health insurance. One example of how this lack of private experience may place CMS at a disadvantage is the concept of value purchasing of health care. In the old world of health insurance upon which Medicare and CMS were modeled, a health plan simply paid claims. The idea that a health care payer should rigorously seek value for money had not yet entered the work of health care. Today this idea is a fundamental goal of today's private health insurance. However, few at CMS have had the opportunity to learn how private health plans try to incorporate value purchasing into their business.

There is a perception among many outside of CMS that the agency has a conscious or unconscious bias against managed care in favor of the traditional fee-for-service program. Our analysis suggests that the problem is actually a general lack of in-house experience with how modern private health insurance plans go their business, whether they are fee-for-service or an HMO.

Some have suggested creating a new agency to manage Medicare+Choice and any potential new drug benefit, leaving CMS to manage the traditional fee-for-service program. Our analysis suggests that a better and sufficient alternative would be to hire new CMS staff with relevant private sector experience. Not only could this strategy invigorate both traditional Medicare program and Medicare+Choice, it would also avoid the potential lack of coordination and confusion for beneficiaries that could result from having two agencies running the Medicare program.

Our work also indicates significant difficulties in CMS's ability to attract sufficient numbers of physicians and experts in cutting edge information technology.

The limiting factor appears to be CMS's salary structure. The agency simply cannot provide compensation sufficient to compete with private health plans for the best and brightest. A number of our interviewees also pointed to the agency's inability to retain talented young professionals at the agency given the better salaries they can garner in the private sector. Even if the number of Medicare beneficiaries receiving their health care through managed care plans, the agency will still require talented staff with a good understanding of private health plans to oversee Medicare+Choice and traditional Medicare.

Among the options Congress may want to consider are adjustments and supplements to CMS's compensation structure sufficient to attract individuals from the private sector, medicine, and the information technology industry. The Public Health Service has the authority to pay Senior Scientist supplements to assure it can retain the talent it needs. Other parts of the federal government also have the flexibility to pay more to maintain a skilled workforce.

Providing CMS staff with the opportunity to be "detailed" to appropriate private organizations for a time would be an additional way for the agency to take on more of the philosophy and relevant best practices of the private sector. According to a 1991 report of the National Academy of Public Administration, 71 percent of HCFA staff at that time were 40 years or older, and 25 percent were 50 years or older.[2] Long-time agency employees have begun to retire and more will do so during the next decade. This presents a golden opportunity to bring new talent and a new outlook to the agency through the natural attrition of current staff.

Information Technology

Computers have been vital to CMS's work since the beginning of the Medicare program. They are the main mechanism for paying providers on time and according to Medicare's rules for reimbursable services. They are also tools in assuring program integrity and quality health care. Through the Medicare Compare database,

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[1] Health Care Financing Administration, Justification of Estimates for Appropriations Committees. Fiscal Year 2001.

[2] National Academy of Public Administration. An Agency At Risk: An Evaluation of Human Resources Management at HCFA. A Report for the Health Care Financing Administration in fulfillment of contract no. 500–90–0018. Washington, DC. September 1991.

we have seen the very beginnings of how information technology might help Medicare better serve its beneficiaries and their families. However, our interviews, along with the excellent work of the General Accounting Office and other's underscore how far CMS's information technology is from achieving its full potential.

Medicare's computer technology is antiquated. Most of the systems were developed in the early 1970s. At that time, data were processed in batches with delays and constraints on one's ability to integrate information from different sources and points in time. This contrasts with current technology in many organizations that allows information to be available to a user as soon as it is entered. Furthermore, CMS and its contractors must update computer code in a patchwork fashion in order to incorporate new payment rules. Two years ago, CMS achieved Y2K compliance in the same fashion. Such patches take time and create a risk for error as the number of patches compound. Delays in the availability of useful data mean they are often not available for policy planning, quality improvement, or program accountability. The lack of timely data also limits the program's ability to solve the problems for individual beneficiaries and providers.

There are also multiple computer systems to support Medicare operations. The number of systems itself is not the problem. In fact, the experience of the Medicare Transaction System (MTS) in the 1990s suggests that it may be inadvisable to expect one system to do everything.

However, it is a significant problem that the various systems cannot easily "talk" to one another. Each fiscal intermediary, carrier, and other Medicare contractor has its own data system. Although all systems are expected to conform to standards, it is difficult (and not routine) to pull data from different contractors to put together a profile of services and payments involving a particular beneficiary or provider, or to look in aggregate across different Medicare services.

How should CMS go about improving its computer systems? To its credit, the agency does have a strategic plan for its information technology. In our interviews, we discussed the MTS experience and the factors that led to its abandonment. Despite the problems with MTS, we found universal agreement that Medicare must invest significantly in its computer systems. Our interviews suggested a few other ideas as well:

- Although Medicare's computer systems should be integrated across different services and contractors, changes should be made in discrete pieces and staggered over time. This will allow CMS to alter later phases of the project to incorporate lessons learned in implementing the earlier phases. It also provides CMS with additional opportunities to measure how well its contractors are fulfilling their obligations and, if necessary, change contractors.
- The scope of work for developing and implementing the new information technology system should be as specific as possible. Several interviewees indicated that a lack of specificity of the contract's scope of work contributed to the failure of MTS. This suggestion underscores the need for CMS to hire additional staff with a thorough understanding of both cutting-edge computer technology and the best management practices of private health plans.
- One interesting idea that emerged from our work is that CMS might commission several prototype systems before settling on a single contractor much as the Department of Defense does when procuring a new jet fighter. Although CMS would spend some money on systems it would not ultimately develop, the agency would reduce the risk of contracting with a single firm that might fail. Furthermore, the final information technology system could incorporate the best elements of each of the prototypes.

The Administrative Budget

CMS has been proud of its lean budget, recently boasting, that Medicare's administrative expenses "are less than two percent [of benefit payments,] far below the private insurance industry average of 12 percent."[3] HCFA's administrative budget includes funds for its contractors, its own staff and infrastructure, the Peer Review Organizations (PROs), and State Health Insurance Assistance Programs (SHIPs). In reality, these amounts have been too low given the growing size of the program and the dramatic increase in the number and complexity of administrative tasks we expect it to perform. Any significant restructuring of the program or the addition of a prescription drug benefit (whether integrated into Medicare or offered through private health plans) will add to Medicare's administrative responsibilities.

In the interest of spending each tax dollar wisely, there may be a tendency to assume that administrative expenditures are wasteful i.e. that they support a govern-

[3] Health Care Financing Administration, "Medicare 2000: 35 Years of Improving Americans' Health and Security" July 2000.

ment bureaucracy rather than directly providing benefits. CMS's unique appropriations process may contribute to this tendency with the result of under-investing in program administration. Most of CMS's administrative funds are discretionary, while federal Medicare and Medicaid health benefits are mandatory spending. For other federal health agencies, such as the National Institutes of Health, administrative budgets are considered together with expenditures designed to improve health. Despite the significant role CMS plays in improving the health and well-being of 70 million Americans, only its administrative budget is the focus of the appropriations process. CMS's administrative budget must compete for funds against human genome research and many other popular programs in the Department of Health and Human Services.

Rather than assuming administrative expenditures could be better spent in some other way, it may be useful to consider them as investments—investments to assure the Medicare tax dollar is spent well, investments to assure that beneficiaries receive quality health care, and investments to assure that providers and suppliers are paid.[4] Under this rubric, the question becomes what return are we realizing for our administrative expenditures. In some cases, we may realize a greater return by investing more money.

One option suggested by others[5] for which there is precedent would be to set the administrative budget for Medicare (and the other mandatory programs for which CMS has responsibility) according to a formula related to benefit payments. This is already done for the Social Security Administration's administrative budget, for Medicare PRO program, and for the SHIP program. In order to maintain accountability and assure an appropriate administrative budget, Congress could review the formula along with CMS's administrative priorities and accomplishments every few years with the advice of Medpac, GAO, or some other expert body. Adjustments should reflect Congress' expectations of the agency. For example, major changes like the adoption of a prescription drug benefit or significant new payment rules for providers should be accompanied by appropriate increases in administrative budgets.

Beneficiary and Provider Services

Services Through Contractors. The reorganization announced by Secretary Thompson this past week stresses the need for CMS to "respond to all constituencies faster and better." Our work suggests that the strain on Medicare's administrative budget has hit provider and beneficiary services particularly hard. Medicare contractors have traditionally been the first and best source of information for physicians and other providers trying to understand Medicare's payment rules and to resolve billing problems. They have also served as a resource for beneficiaries trying to resolve problems or confusion over their Medicare claims. As budgets have become tighter in recent years, contractors have received less for provider and beneficiary services. Funds for provider education have held steady at $15.8 million over the last three years, down from $31.4 million in FY 1995.[6] Funds for beneficiary communications have held steady at $181.6 million for the last two years. Because contractors' first priority is to pay claims in a timely fashion, their ability to provide beneficiary and provider service has suffered.

For providers, an important element of the services they need from contractors is education and guidance about billing and reimbursable services. The vast majority of providers want to bill Medicare correctly for the services they provide to beneficiaries, but they need help in understanding the complexities of Medicare's rules. At a time when Congress has made the elimination of improper payments a priority for Medicare, such education is a vital.

Carriers and fiscal intermediaries should also be in the best position to help beneficiaries understand how the Summary of Benefits forms they receive relate to the care they have sought and any bills providers have sent to them. We found strong support among our interviewees for providing contractors with the necessary funds to provide these important services.

Other Sources of Information for Beneficiaries. Our analysis and the opinions of the experts with whom we spoke indicate that CMS has come a long way since 1997 in developing written materials explaining Medicare and the choices available to beneficiaries. Much thought, research, and testing has gone into the

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[4] Blumenthal, D. "Administrative Issues in Health Care Reform," New England Journal of Medicine. 329 (August 5, 1993) 6: 428–429. U.S. Congress, Office of Technology Assessment, International Comparisons of Administrative Costs in Health Care, BP–H–135. Washington, DC: U.S. Government Printing Office, September 1994.

[5] See for example, Vladeck B.C. and Cooper B.S. "Making Medicare Work Better," New York: Institute for Medicare Practice, Mount Sinai School of Medicine. March 2001.

[6] Tilson S., Congressional Research Service. Memorandum to the Senate Finance Committee on "HCFA Budget, Organization, and Staffing Information." Washington, DC. January 30, 2001.

Medicare Handbook that each beneficiary receives in the fall as well as the Medicare Compare website, the toll-free telephone line, and the information available to private organizations that help beneficiaries understand their benefits and choose a health plan.

While these resources are now excellent, comprehensible references for beneficiaries and their families, the next step is for CMS to develop better resources to help beneficiaries with their own particular needs. Other research that my colleagues and I undertook at NASI indicated that most beneficiaries seek information only when they need it and look for information tailored to their individual health and financial circumstances.[7] In choosing a health plan,[8] beneficiaries seek a plan with particular benefits they think they will need. When beneficiaries encounter problems with claims or coverage, they seek out individuals who can resolve the situation and offer clear individualized explanations.

Current sources of individualized help are limited. The toll-free telephone line is limited to helping beneficiaries make health plan choices. In an effort to assure that beneficiaries receive correct information, the telephone agents work from scripts. They do not attempt to give individualized advice. They refer beneficiaries with claims problems to the appropriate Medicare contractor. They can also refer beneficiaries to the SHIP in their area. Our interviews suggest that the SHIPs are under-funded and vary from state to state in how well they meet beneficiaries' needs. They all rely on volunteers. In some SHIPs, close contact with the contractors and CMS regional offices facilitate solving beneficiaries' problems. In other states, the relationships with contractors and regional offices are less well-developed.

The limited resources for individualized beneficiary help has led some to suggest that CMS itself should have a local presence, such as one employee in each Social Security district office. Others in our interviews have suggested that the internet and modern telecommunications would allow CMS to provide the same individualized service in a more cost-effective manner. Our initial analysis suggests that the right course of action is not obvious, and we will be conducting a more detailed examination of these options in the coming months. However individualized beneficiary services are provided, the counselors need competent and ongoing training as well as good access to data and individuals from the local carriers, intermediaries, and regional offices.

Contractor Reform

In the area of more contractor reform, the types of restrictions placed on Medicare contracting in the 1965 statute appear out-of-sync with the complexity of the current health care marketplace and Medicare. We found strong support in our interviews for continuing to reduce the number of contractors as well as for furthering the flexibility first given to CMS as part of HIPAA in the types of services for which the agency may contract. Other suggestions that we have not yet analyzed in any detail include more competitive selection of contractors and tying some part of contractor compensation to objective measures of their performance.

Other Issues

In my testimony, I have focused on issues where we have found some agreement across the experts with whom we spoke. There are other questions where there was less consensus and for which we will do additional analysis to characterize the problems and potential solutions. For example:

- Over the last two years, CMS has implemented an impressive transformation in its process for national coverage decisions to make them more transparent and evidence-based. However, several important questions still remain: What should be the role of national coverage decisions versus contractor and regional decisions in evaluating new medical technologies, particularly as biomedical innovation changes medical practice at such a fast pace? What criteria should be used in making coverage decisions? Can and should such decisions be insulated from the political process?
- CMS has ten regional offices around the country. Our interviews suggest a potential lack of coordination between the regional and central offices in some aspects of Medicare operations. What roles should these regional offices play, and how can we assure sufficient coordination and communications?

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[7] Bernstein J., Gluck M.E., "Medicare Managed Care and Choice: What Do Californians Have to Say," in Iglehart, J.K., ed., Medicare and Managed Care: A Primer from Health Affairs and the California HealthCare Foundation. Millwood, VA: Project Hope, 1999.

[8] In this case, health plan refers to either the traditional fee-for-service Medicare program or a Medicare+Choice option.

- A number of interviewees as well as other recent policy reports[9] have suggested making CMS an independent agency outside of the Department of Health and Human Services as was done for the Social Security Administration. What are the pros and cons of this proposal?

As my colleagues and I grapple with these questions in the current months, we would be happy to share our analyses and conclusions with you.

I thank you for this opportunity to participate today, and I am happy to answer any questions you may have.

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Today's hearing gives us an opportunity for a progress report on the efforts of Secretary Thompson and his team to strengthen the administration of Medicare and Medicaid. These programs are critically important to our constituents, and we must make them work better.

In my view, right now it is surely too soon to expect major results from the new team. Secretary Thompson, you've been on the job five months, and Administrator Scully has been in place for less than a month. So I assure you that this hearing is by no means a "final exam." As you know well, there is much more to do; I noticed that the reforms you announced on Thursday were described as "First Steps." So you clearly recognize that there are many more steps ahead.

But I do want to make it clear that I have been impressed by your initial efforts, Secretary Thompson, and those of Administrator Scully. The President chose you for these jobs because you are well-known as can-do reformers who would shake up the bureaucracy. You've been a breath of fresh air.

Today, I do want to hear more details on the changes recently announced for the agency now known as the Centers for Medicare & Medicaid Services (CMS). I am particularly interested in learning more about your ideas for the Medicare education campaign, because I have long felt that we need to do much more to educate beneficiaries about the often-confusing Medicare program. And now that you've taken these "First Steps," I also want to hear your ideas on what the "Next Steps" might be.

I am also interested in CMS's ability to administer major program improvements that I hope we will enact this year, including a prescription drug benefit. I look forward to working closely with you to continue to improve the efficiency and responsiveness of CMS.

PREPARED STATEMENT OF JUDITH HIBBARD

Chairman Baucus, and members of the Committee, thank you for this opportunity to testify. I am Judith Hibbard from Eugene, Oregon. I am a professor in the Department of Planning, Public Policy, and Management at the University of Oregon and Clinical Professor of Public Health and Preventive Medicine at the Oregon Health Sciences University. I am a member of the Strategic Framework Board (SFB) of the National Quality Forum, where I provide expertise on how to effectively report health care information to consumers. I am pleased to be here today to discuss the information needs of Medicare beneficiaries.

My research interests focus on how consumers can make choices that will help to ensure that they gain access to the best quality of care that is available to meet their own needs and preferences. In this context, I have investigated how consumers make choices, and how these choices vary depending on how well they understand the information and how that information is actually presented. I have studied consumers of all ages, including Medicare beneficiaries. My current research has been supported by the Centers for Medicare and Medicaid Services (formerly HCFA), the Robert Wood Johnson Foundation, and the AARP.

As you know, the Medicare Program works best when beneficiaries make informed choices about their options. Recent changes in the program have expanded options as well as the amount and type of information available to beneficiaries. This represents a new situation for beneficiaries. They now need to understand the various choices available in their local area, how they differ, and how those differences might affect their costs and their care.

My research has focused on how beneficiaries are faring under these new conditions of more choice and more information. What we have found is that there are serious deficits in what beneficiaries know about how Medicare works, and what

[9] Vladeck and Cooper, op. cit.

they understand about the differences between the original Medicare program and managed care options. Even in areas were there are many managed care options, the majority of beneficiaries have very little understanding of the differences or what they should be considering when making a choice.

Of greater concern is our recent finding that more than half of the beneficiary population has difficulty understanding the comparative information about Medicare options *(Older Consumers' Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment,* Sept. 2000). When asked to review comparative tables or charts showing plan characteristics or how well health plans perform, a majority of beneficiaries had difficulty accurately interpreting the information. Compared to the population under 65 years of age, older beneficiaries make about 3 times as many errors in interpreting information *(Health Affairs,* May 2001). Those who were older (80+), who were in poorer health, and who had less education had the most difficulty using information. Those beneficiaries who had the most difficulty also felt that having many choices and lots of information was a burden. They preferred to have someone else make Medicare plan decisions for them. A surprising finding was that the beneficiaries who had the most difficulty were no more likely to seek formal help than beneficiaries who were more able to understand and use information in making choices.

At the same time, almost half of beneficiaries were able to correctly interpret comparative information. These beneficiaries who have more skill, do welcome the expanded Medicare choices and having the information to inform those choices. These findings underscore the importance of segmenting the population and tailoring information to meet the needs of the diverse segments.

Research findings have important implications for the Medicare program.

- What beneficiaries need to know to make an informed choice is formidable. They need to understand how managed care versus the fee-for-service program will affect their costs, their access, and the quality of their care. They need to be able to understand the performance information associated with each of their plan options and bring this information together with the information about plan characteristics, benefit packages, and cost. They need to be able to differentially weight these factors to match their own needs and preferences. While these tasks are difficult for most people, they are particularly difficult for the elderly. Beneficiaries need assistance with this process.
- The most effective approach to communicating with beneficiaries will take into account the tremendous differences within the beneficiary population in their ability to comprehend and use information in choice. *Educational approaches and communication strategies need to be tailored to the different segments and their ability levels.* This implies putting sufficient resources into the communication and education budget to accommodate tailoring of information.
- Because they are the least able to make informed choices, it is important to identify those beneficiaries who have more difficulty in using information and provide them with the needed assistance. Using a simple screening approach may enable Medicare counselors to identify those with the least ability to use information on their own. Triaging individualized in-person help to these beneficiaries is probably the best way to use what is likely to be a limited resource.
- Providing decision-support by helping beneficiaries understand and apply information to their own situation, helping them weigh the different factors, and enabling them to bring these all together into a choice is the kind of assistance that beneficiaries most urgently need. This means providing help that goes beyond simple information dispensing, which is what most current CMS and SHIP efforts entail, to providing decision-support. Decision-support can be provided via group counseling, individual in-person or telephone counseling, or through the provision of decision-support computer tools. Most beneficiaries prefer decision-support help in the form of one-one-one counseling with a live person. For example, placing a Medicare representative in each Social Security office to answer questions and provide information is one way to make expert help more available to people in their local communities.
- Making the choice task easier for beneficiaries would also help them make better selections. This could be accomplished by having fewer types of plan designs to choose from and less complexity associated with each of the choices. Medigap choices were simplified by standardizing options and language, and similar approaches could be taken with the Medicare+Choice options.
- The National Medicare Education Program requires adequate resources. The complexity of the options and the diverse abilities of the Medicare population, make beneficiary education and communication an especially challenging task.
- Finally, because most beneficiaries still lack an understanding of their choices, it is premature to implement the lock-in feature of the Medicare+Choice pro-

gram scheduled to begin in 2002. The lock-in was built on the assumption that beneficiaries would understand their options and make careful and appropriate choices. At the present time, this is obviously not the case.

Providing information does not equal understanding. Beneficiaries have been provided with information but many still do not have enough understanding to make informed choices. It will be very important for the new Centers for Medicare and Medicaid Services (CMS) to assess beneficiary knowledge levels on an ongoing basis to determine the degree to which their educational efforts are actually successful.

I was pleased to hear Secretary Thompson's announcement that beneficiary education and outreach will become a higher priority. This is an important step. As the Medicare program becomes more complex, many beneficiaries will need individual help to make good choices. The amount of help they will need is likely proportional to the number of choices and the complexity of those choices. The Centers' challenge is to improve communications to beneficiaries by tailoring information for the diverse Medicare population, and to find ways to provide assistance to beneficiaries that moves beyond information dissemination to education and decision-support.

Attachment.

#2000-14
September 2000

Older Consumers' Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment

by
Judith H. Hibbard, Dr. P.H.
Paul Slovic, Ph.D.
Ellen Peters, Ph.D.
Melissa Finucane, Ph.D.

The Public Policy Institute, formed in 1985, is part of the Research Group of AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion and do not necessarily represent formal policies of the Association.

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Executive Summary

Background

Recent changes in the Medicare program increase the potential health plan options available to Medicare beneficiaries. Along with the expanded choices, there is also an unprecedented effort by federal agencies, health providers, advocates, and others to inform older Americans about their health options. Most of Medicare's 39 million beneficiaries receive a detailed booklet annually describing the choices. Beneficiaries can also call a toll-free number for information, or go to a counseling center or the Internet for additional help.

Purpose

How well do older Americans handle these new demands for using information and making choices? Little is known about older adults' ability to use information in decision making and the degree to which they possess the skills needed to make sound decisions. The goals of this study are to begin to assess decision skill among Medicare beneficiaries and to assess the relationship between decision making skill level and how much assistance in decision making is desired. The study explores whether those who are most likely to seek help are the ones most in need of assistance. Specific research questions are:

- Can we measure decision skill among Medicare beneficiaries?
- Do Medicare beneficiaries who have poor decision skills have a greater desire to delegate decisions and/or to have help in making decisions than beneficiaries with better decision making skills do?
- Are beneficiaries who have less decision skill more likely to view having and making choices as burdensome?

Method

This study employs a cross-sectional analysis to address the research questions. A convenience sample of 253 Medicare beneficiaries was recruited and paid for participation in the study. Beneficiaries were recruited at Eugene/Springfield, Oregon senior centers. Study participants are an average age of 75 years, with ages ranging from 65-94 years. Sixty-one percent of our study population is female. Twenty-four percent have a college degree or higher, while only 9 percent have less than a high school education. Only 17 percent of the study population rate their health as fair or poor, while 25 percent of the total Medicare population rate their health as poor or fair. The study sample has higher educational levels, has better self-reported health, and is younger than the Medicare population as a whole.

A preliminary index of skill was constructed that appears to be both valid and reliable. The index assesses an individual's ability to interpret comparative information accurately for use in making health plan choices.

Findings

- *A large proportion of study participants lacks the skills to use comparative information in health plan decisions.* Many had a high error rate (30 percent or more errors), indicating they could not accurately use information to make informed choices on health plan options. Out of 35 decision tasks, the average participant made errors in 25 percent of them.
- *Medicare beneficiaries differ enormously in their ability to use comparative information in making choices.* Those in the bottom quartile of performance had a 57 percent error rate on average, while those in the top quartile averaged only 5 percent errors.
- *Based on a proxy measure of skill, an estimated 56 percent of the total Medicare population has difficulty accurately using comparative information to make choices.*
- *Many Medicare beneficiaries feel burdened by making choices.* Those with less skill viewed Medicare decision making as burdensome. Compared to those with higher comprehension skill, they more often preferred to delegate these decisions.
- *Those with less skill are no more likely to seek help than those with higher skill are.* Those who are seeking assistance are not necessarily those who need the most help.

Summary

The findings from this study indicate that using comparative information to inform health plan choice is a difficult task for most Medicare beneficiaries. The degree of diversity of functioning within this population is a key issue for shaping interventions to inform and educate these individuals and support their decisions. This suggests that strategies aimed at an older population need to be tailored to skill level rather than to a homogeneous group. Identifying those with low skills and providing supports should be a priority. Aggressive outreach to those with less skill may be needed. Consideration should also be given to policy approaches that will simplify the choices Medicare Beneficiaries must make.

Even though preliminary, the findings are significant, in that they point to alternative policy directions and suggest the need for additional research to inform current policy. Given that the study sample has higher educational levels and reports better health than that of the Medicare population as a whole, the study sample is likely higher functioning than the general Medicare population is. Therefore, comprehension skill among Medicare beneficiaries generally may be lower than the level observed in the study sample.

Foreword

The Balanced Budget Act of 1997 authorized several coverage options for Medicare; collectively, these options constitute the Medicare+Choice (M+C) program. Although most of the authorized plan types have yet to appear in the Medicare marketplace, their inclusion in M+C signaled Congress' intent to make Medicare look more like the private sector. In addition, creation of M+C has served to heighten awareness among policymakers, researchers, and advocates of the importance of providing information and conducting educational activities to help Medicare beneficiaries make informed health care choices.

Being an informed health care consumer means being able to take in and process a myriad of details about complex concepts and topics. Aside from choices concerning their clinical care, beneficiaries must be able to understand information about costs, benefits, and health care quality. Most Medicare beneficiaries have, at a minimum, a choice of at least the Original Medicare Plan and one health maintenance organization (HMOs), so they must be able to compare the differences between these two options. In locations where there are several HMOs, they must also be able to distinguish differences among plans on the basis of costs, benefits, and quality of care.

To support informed choice, the Health Care Financing Administration (HCFA) has embarked on a major, multifaceted information and educational initiative, the National Medicare Education Program. Although this program is providing needed information, much remains to be done to ensure that beneficiaries can actually make informed choices.

The present study by Judith Hibbard of the University of Oregon and colleagues from Decision Research examines the ability of Medicare beneficiaries to use and understand comparative information. Specifically, Dr. Hibbard explores the question of how the decision-making skills of beneficiaries can be measured, with the objective of creating an index of those skills that could be used by those who provide information to Medicare beneficiaries. This could help them better tailor their efforts to the individual needs of their clients.

AARP was pleased to sponsor this study under a Memorandum of Understanding with HCFA's Center for Beneficiary Services. We continue to be interested in exploring M+C's consumer choice strategy. Many researchers are studying how to help Medicare beneficiaries adapt to the new emphasis on choices, so that they can navigate within the new structure; we agree that this is an important line of inquiry. It may also be productive to explore how well beneficiaries are likely to fare in a system based on informed choice. Is a program based on this strategy the correct approach for the Medicare program? Do all Medicare beneficiaries value having a wide range of health coverage options? Can all of them use comparative information to make informed choices? Is the information burden too great, or is it manageable?

Although this is a preliminary study, the findings, if confirmed by further research, could have significant public policy implications. At a minimum, they suggest the importance of recognizing the diversity of the beneficiary population and the need to tailor

materials and strategies to support their different capacities and needs. The findings also call into question whether some of the current features of M+C are appropriate for certain segments of the older Medicare population. For example, given the finding that many who are over 80 years old cannot adequately understand comparative information, is a program based on the need to select from among multiple plan options a workable program design? Is the "lock-in" provision that will keep M+C enrollees in the same risk-based plan (initially for six months in 2002, then nine months in 2003 and subsequent years) suitable for beneficiaries who may not be able to understand the implications of their choices? Clearly, more research must be conducted to confirm the findings of this study. AARP is committed to ensuring that the Medicare program remains responsive to the needs of the entire beneficiary population. We encourage HCFA and others to continue learning how best to accomplish this objective.

Joyce Dubow
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Introduction

Recent changes in Medicare broaden the possible array of enrollment options available to the program's beneficiaries. These new choices reflect a growing complexity of insurance mechanisms and delivery system options. While most of these new options have not yet materialized, HCFA has begun to provide more information about the characteristics and performance of HMOs, the predominant plan type that is available. The assumption is that, provided with information to explain the available options, beneficiaries will be able to make choices that fit their individual needs and preferences. There is also the hope that with comparative performance information, beneficiaries will choose higher-performing plans and that this, in turn, will increase incentives for health plans to improve care and patient satisfaction.

Little is known about how well older adults can process and use comparative information in making choices, or how much information they can effectively use. Whether Medicare beneficiaries view having more health plan options as an advantage or as a burden is also not known. Understanding these questions is particularly important as we evaluate different possible directions for the future of the Medicare program. For example, several of the options under consideration take Medicare in the direction of a premium support program. This approach would rely on the market to provide a wide array of options and would place a greater burden on Medicare beneficiaries to be able to understand those options and their potential personal, financial, and health care consequences.

The research questions addressed in this study are:

- Can we measure decision skill among Medicare beneficiaries?
- Do Medicare beneficiaries who have poor decision skills have a greater desire to delegate decisions and/or seek assistance in making decisions than beneficiaries with better decision making skills do?
- Are beneficiaries who have less decision skill more likely to view having and making choices as burdensome?

The current study is done through a memorandum of understanding between AARP's Public Policy Institute and the Health Care Financing Administration (HCFA). The data were collected under a HCFA contract.

Background

To use comparative information in making health care choices, consumers need several skills. At the basic level is the ability to understand comparative information, then apply it to one's own situation, interests, and needs. Being able to differentially weight the various factors under consideration (e.g., costs, benefits, different performance dimensions) according to one's needs and preferences is a complex cognitive task. Similarly, making trade-offs among the factors under consideration and bringing all the factors together into a choice are cognitively difficult. While little is known about the ability of older adults to carry out these steps in the decision process, there is evidence that aging-related changes in cognitive functioning could

influence these abilities (Hershey et al., 1990; Light, 1994; Meyer et al, 1993; Salthouse, 1986; Zacks & Hasher, 1997).

Older consumers face a number of barriers to being able to use comparative information effectively to make plan choices. These multi-layered barriers range from age-related declines in cognitive and physical functioning to literacy and knowledge deficits.

Studies of cognitive aging reveal that there are age-related declines in information processing with respect to speed, memory capacity, reasoning, problem solving, and text processing (Hershey et al., 1990; Light, 1994; Meyer et al., 1993; Salthouse, 1986; Zacks & Hasher, 1997). Older adults may also have a decreased ability to ignore extraneous information (Salthouse, 1991; Salthouse 1996; Hasher & Zacks, 1988). As a result, it may be difficult for them to find the relevant information when reviewing multiple pages of text or tables. In addition, because of these cognitive changes, older adults often have difficulty in switching tasks, for example, switching from reading about differences in premiums to comparing quality measures. Poorer performance on these different cognitive tasks likely translates to poorer performance on decision making tasks (Schwarz, Park, Knauper, & Sudman, 1998). At the same time, older adults may actually perform better than younger persons on decision tasks in other ways. For example, because older adults have more life experience, they may have better everyday problem-solving skills (Cornelius & Caspi, 1987).

Almost all of the research on decision making has excluded older adults. As a result, very little is known about how older adults integrate information into decisions and how the presentation of information affects their interpretation and use of that information (Peters, Finucane, MacGregor, & Slovic,(2000); Schwarz, Park, Knauper, & Sudman, 1998). There is general evidence that older adults seek less information about medical decisions, make important treatment decisions more quickly, and exhibit less sophisticated reasoning about decisions (Meyer, Russo, & Talbot, 1995; Park et al., 1999). There also appears to be a high degree of diversity of functioning in this population (Park, Morrell, & Shifren, 1999). One source of this diversity may be variation in the rate of decline in cognitive function. There are a variety of reasons for this heterogeneity, including variation in physiological functioning, the presence of multiple comorbidities, differences in life experience, and differences in social history and ethnic background. This diversity suggests that some older adults will be competent at using comparative information to inform their choices, while others will need substantial help.

In addition to age-related cognitive changes, knowledge deficits about the health care delivery system are barriers to older adults making informed health plan choices. Most Medicare beneficiaries have low levels of knowledge about Medicare and the different options they have within the program (McGee, Sofaer, & Kreling 1996). To be able to decide between the original Medicare program and a Medicare managed care plan, beneficiaries need to understand what the differences are. Hibbard et al. (1998) found that knowledge levels about these differences were very low in high penetration Medicare managed care markets. Those enrolled in managed care plans had significantly lower knowledge levels than did beneficiaries in the original Medicare program.

Educational and literacy levels are other factors that affect the ability to use comparative

information in making choices. The National Adult Literacy Survey (National Center for Education Statistics, 1999) estimates that 39 percent of those age 60 and older function at the lowest literacy level (level 1), compared to 16 percent of the total population who function at this level. Those at literacy level 1 cannot read at all or can locate only one piece of specific information in short, uncomplicated text, such as a short newspaper article. The literacy study also indicates that a high percentage of those age 65 and older have difficulty reading tables, charts, and graphs.

Methods

Study Design, Sample, and Data Collection. This study employs a cross-sectional analysis to address the research questions. The study uses a convenience sample of 253 Medicare beneficiaries. Participants were recruited and paid for their participation. Recruitment and data collection took place primarily at Eugene/Springfield, Oregon senior centers. Participants were asked to review information and complete several decision tasks related to using comparative information in making health plan selections.

Only aged Medicare beneficiaries were included, and there was no upper age limit on participation. Because recruitment took place at community centers, homebound and institutionalized beneficiaries were *de facto* excluded.

Table 1 shows the characteristics of the study sample and how it compares to a nationally representative sample of Medicare beneficiaries (Medicare Current Beneficiary Survey [MCBS], 1995). Study participants are on average 75 years old. Ages range from 65-94 years (Table 1). Sixty-one percent of the study population are female. Twenty-four percent have a college degree or higher, while only 9 percent have less than a high school education. A similar pattern is found with regard to household income. Only 17 percent of the study population rate their health as fair or poor. The study sample is younger, has higher educational levels, and reports better health than that of the Medicare population as a whole. *Thus, the sample is likely higher functioning than is the Medicare population as a whole.*

Variables.

The main **dependent variable is** the comprehension index that assesses the ability to accurately interpret and use comparative information. This index examines whether participants can correctly understand the information presented in tables, charts, and text form. It also assesses ability to make optimal choices when viewing unambiguous data.

The comprehension index summarizes performance on 35 decision tasks (see Appendix C). These decisions involved interpretation of data presented in different ways, including interpreting text, bar graphs, tables with numbers, and data displays that use symbols instead of numbers. The score on the comprehension index represents the number of errors made in interpreting unambiguous data and/or making suboptimal choices, such as choosing lower-performing plans within given cost strata. The score on the comprehension index measures the respondent's ability to accurately use comparative

information.

Variables used as validity checks to the comprehension skill index.

Two variables that, on their face, would seem to be related to the comprehension skill index are used to assess construct validity.

- *Self-rated skill in using comparative information in choices* is a single item with these response categories: excellent, good, fair, and poor.
- *Self-rated ability to understand the differences between Medicare HMOs and original Medicare* is a single item with these response categories: excellent, good, fair, and poor.

Predictor variables include social, demographic, and health status measures. In addition, we developed several indices to assess experiences with decision making, and an index for possible use as a screening tool. The indices are listed below.

The decision burden index is a simple summated index based on a factor analysis. The seven items in the index focus on the degree to which choices and decisions are viewed as burdensome by study participants. Index scores range from 7-28, with a mean of 17. A higher index score indicates a greater perceived burden associated with making Medicare choices. The index is reliable with a Cronbach's alpha of .8. The seven items are:

- I prefer not to have the responsibility for choosing.
- I am more likely to make a wrong choice if I have lots of different options to choose from.
- Choosing a Medicare health plan is a task I would rather avoid.
- I often feel overwhelmed because there is too much information about each health plan to take in.
- I have difficulty understanding all the information about each Medicare health plan.
- Whenever I make a choice, I worry it will be the wrong one.
- Instead of choosing myself, I'd rather have a family member or close friend help me decide which Medicare plan to choose.

Desire for choice/information are two separate items that ask about wanting choice and information to support Medicare choices:

- I am more likely to make a good choice if I have lots of different options to choose from. (Strongly Agree, Agree, Disagree, Strongly Disagree)
- I prefer to have lots of information about each Medicare health plan choice. (Strongly Agree, Agree, Disagree, Strongly Disagree)

Seeking decision assistance is measured using two separate items. One asks about the likelihood of seeking help in the coming year. The other item asks the respondents whether they have ever sought assistance. Both items have four response categories; however, because of low responses to some categories, only dichotomized versions of the

items are shown in the analysis:

- If you had to make a choice of a Medicare health plan in the coming year, how much assistance would you seek in making that choice?
- Have you ever sought assistance when you needed to choose a health plan?

The screening index is a three-item index made up of education, age, and self-rated health. It is highly related to the comprehension skill index, and is used in the analysis as a proxy measure for comprehension skill. It is also used to estimate the prevalence of comprehension skill deficits in the Medicare population. The index is constructed using an additive non-linear approach with the weighting derived from regression analysis. The index ranges from 3-17. Scoring is: age: (65-69=1), (70-75=2), (75-79=3), (80+=7); education: (post college=1), (college=2), (some college=3), (high school=3), (less than high school=5); Self-rated health: (excellent=1), (very good=2), (good=3), (fair=4), (poor=5).

Findings

- ***How can we measure decision skill among Medicare beneficiaries?***

Making decisions requires skills in several areas: Being able to interpret unambiguous data correctly is the lowest level skill involved in using information for decision making. Most comparative information includes multiple factors and often has no obvious dominant choice. Decision making requires accurate interpretation, as well as much higher-level skills. These include being able to identify the important factors to integrate into a decision; making trade-offs; and bringing all the factors together and weighting them in ways that match one's individual needs and values. The comprehension index was originally conceptualized as a way of capturing a range of these skills. However, it became clear that the lowest-level skill, just being able to interpret unambiguous data comparing options on one dimension, was a serious barrier for a significant portion of the study population. Thus, we have focused our measurement and assessment of comprehension on this most basic level of performance.

Reliability and validity of comprehension index. A preliminary index to assess comprehension was created. The 35-item index is highly reliable with a Cronbach's alpha of .9. One indication of the validity of the comprehension index is whether it correlates with other measures that also measure ability to understand and use information. Two factors were chosen for this validity check: (1) self-rated skill in using comparative information; and (2) self-assessed understanding of the differences between original and Medicare managed care. In fact, both factors are highly correlated with the comprehension index score. Those who have poorer skills seem to recognize their lesser skill and rate themselves lower (Figure 1).[1]

At the same time, those who say that they have a poor understanding of the differences between original and Medicare managed care also tend to score poorly on the comprehension index (Figure 2). That is, those who are more confused about Medicare also have more difficulty

1. The item asking respondents to rate their own skill came after they had been asked to complete several decision tasks using comparative information. It is possible that their rating might have been different if they had been asked to rate their decision skill prior to the decision tasks.

understanding comparative information about the health plan options.

- ***Are there differences among Medicare beneficiaries in terms of their comprehension skills?***

An initial examination of the comprehension index indicates that there is *a high degree of variability* within the older population concerning their ability to interpret information accurately (Figure 3). Out of 35 decision tasks, the average number of errors was 8.7, or a 25 percent error rate. The range of performance on these tasks was 0 errors to 28 errors. Those in the bottom quartile of performance had an average of a 57 percent error rate, while those in the top quartile averaged only 5 percent errors.

Because the study population was recruited from local senior centers, the participants are socially active and engaged. They are overall in better health, have higher educational levels, and are younger than the general Medicare population is (Table 1). Thus, participants are likely better functioning than the larger beneficiary population is. This is important to keep in mind in reviewing the level of skill observed within the study population.

- ***What beneficiary characteristics predict skill?***

A number of factors are strongly related to performance level on the comprehension index: self-rated health, education, and age (Figures 4-6). Those with poorer health, and less education, and those who are older, tend to score lower on the index. After age 80, there is a large drop-off in performance. Those who are 80 years or older have about four times the number of errors compared to those who are 65-69 years old. It is also interesting to note that higher education levels are related to improved performance on the comprehension index, until age 80 (Figure 7). After age 80, education is unrelated to performance. This suggests that the observed lower performance in older age groups is not just a literacy effect, but an aging effect as well.

- ***Do Medicare beneficiaries who have poor comprehension skills have a greater desire for assistance in making choices than beneficiaries with better comprehension skills do? Do they view having and making choices as being more burdensome than those with more skills do?***

Thirty-seven percent of the study population prefers to delegate Medicare health plan decisions. A desire to delegate these decisions is highly correlated with performance on the comprehension index. Those who have the lowest comprehension scores (e.g., highest error rate) are also more likely to have a greater desire to delegate Medicare decisions to an expert (Figure 8). In addition, those with lower comprehension skill are also more likely to view Medicare choices as burdensome. Those with the highest error rate score the highest on the decision burden index (Figure 9). That is, those with less skill view having more information and more options to choose from as an unwelcome burden. In addition, those with less comprehension skill are also more likely to say they would like to have a friend or family member help them decide on a Medicare plan (Figure 10).

However, those beneficiaries who score poorly on the comprehension index are no more likely to say they will seek help on a Medicare health plan decision in the coming year than are those who score higher (Figure 11). Similarly, beneficiaries who have high errors are no more likely to say they had sought help in the past on a Medicare plan decision (Figure 12) than are those with low errors. Thus, although those with poor comprehension skills indicate a greater willingness to delegate decisions, they apparently are no more likely to act on this by seeking decision assistance. The desire to have someone else decide may be just a passive desire. Seeking assistance requires taking action.

At the same time, those who want to have more choices and desire a lot of information to make choices tend to be those who have more comprehension skill (Figures 13 and 14).

- ***Can we estimate what portion of the Medicare population would have difficulty using comparative information in choices?***

We created an index of the variables that are highly related to comprehension skill score: age, education, and self-rated health status for possible use as a screening tool. The creation of this tool is very preliminary, as are estimates we generate from them. It appears that with this screening index, we can predict with 70 percent accuracy whether a beneficiary falls into the higher or lower scoring region of the comprehension index. That is, for those beneficiaries with a median score or above on the screening index, there is a 70 percent probability that they will have a median score or higher (high errors) on the comprehension index.[2] Figure 15 shows the scatter-plot of the study population distributed on both the screening index and the comprehension index.

Because the study population is a convenience sample, it is not possible to generalize to the larger beneficiary population. However, because we are able to predict with a relatively high degree of accuracy performance level on the comprehension index, using the screening index as a proxy for skill, we can estimate the proportion of the population that is likely to perform at the high and low ends on the comprehension index. *This estimate is based on the assumption that the screening index is a reasonable proxy for comprehension skill. Because this assumption needs further testing, the estimate should be viewed as preliminary.*

We can estimate the percentage of the beneficiary population that would have a high or low score on the comprehension index by recreating the screening index, using a nationally representative survey sample (MCBS) (Figures 15 and 16). Based on the MCBS survey population, 63 percent of the population scores eight or higher on the screening tool, and 37 percent would score below eight.

Using the findings from our study sample and assuming that the screener is a valid proxy for comprehension skill, we can estimate the expected percentage of true positives, true negatives, false positives, and false negatives if we used the screening tool in the larger Medicare population. For example, for the 63 percent who had a high score on the screening index, we would expect 70 percent to have a high error score. Thus, .63 X .70 = 44, or 44 percent of the total population would be true positives. We would also expect about 37 percent of all

2. Comprehension skill index is dichotomized on median score.

beneficiaries to have a low score on the screening index. Of those 37 percent, 33 percent would be false negatives (that is, they would actually have a high error score on the comprehension index). Therefore, we would expect 12 percent of the population to be false negatives (.37 X .33 =12 percent).

Altogether, we would expect about 56 percent of the beneficiary population to score on the high-error end of the comprehension index (true positives + false negatives =.44+.12 = 56 percent).

To summarize, if we tested the whole beneficiary population and scored it on the comprehension index **and** on the screening index, we would expect to find that about 44 percent of the population (or about 17 million beneficiaries) had a high error rate and had a high risk score on the screening tool. We would also expect to find that about 5 million beneficiaries would have a high error score on the comprehension index but would fall into the low risk end of the screening index (false negatives on the screening test). Thus, using the comprehension index alone, about 22 million beneficiaries would be identified as having difficulty in using comparative information. However, if just the screening tool were used, 17 million beneficiaries would be correctly identified as having difficulty in using comparative information, while 5 million would be missed.

Based on these estimates, about 22 million beneficiaries would have a median error rate of 17 percent in using comparative information.[3] Since we don't really know what level of error would define inability to use comparative information, in this analysis, we used the median error rate for the study population. We can, however, estimate how many beneficiaries would have an even higher error rate (higher than median). For example, based on our estimates, about 11 million would have a 30 percent error rate in using comparative health plan information.

These estimates are preliminary and are based on the assumption that an index of age, education, and self-rated health status can serve as a proxy measure of comprehension skill. Further testing with both the comprehension index and the screening tool would be needed to confirm the validity of both estimates.

Discussion

The results of this study show that using comparative information to inform health plan choice is a difficult task for many beneficiaries, likely, the majority of them. Nevertheless, the findings should be considered preliminary, in that they are based on a small convenience sample. Nevertheless, the findings are significant, as they strongly suggest the need for further work in this area, particularly work that examines larger, more representative samples and provide a first look at skill level in the Medicare population.

It is important to note that the findings reported here likely overestimate skill level in the beneficiary population. First, because the sample is younger, in better health, and better

3. Seventeen percent is the median error rate from the study population.

educated, it likely reflects a higher-functioning population than the beneficiary population as a whole. Second, we measured only the lowest level of skill needed for decision making: comprehension. It is probably safe to assume that if we had a measure of decision-skill that included higher-level cognitive skills used in decision making, we would observe a much higher percentage of the population with serious deficits for making decisions. We estimate that 56 percent of the Medicare population has difficulty with just the comprehension of comparative information, the lowest level skill needed for decision making.

In addition to observing high errors for the population as a whole, we also observed that there is a high degree of variability within the older population with regard to being able to interpret information accurately. Out of 35 decision tasks, the average number of errors was 8.7 or a 25 percent error rate. The range of performance on these tasks is enormous. Those in the bottom quartile of performance had an average of a 57 percent error rate, while those in the top quartile averaged only 5 percent errors.

Those with lower comprehension skill are more likely to view Medicare choices as burdensome and prefer to delegate the task to others. However, this greater desire to delegate is apparently not acted upon. Those beneficiaries with lower skill are no more likely to say they will seek help on a Medicare health plan decision in the coming year than are those with higher skill. Those with less skill appear to be passive in their desire for help. They feel burdened by Medicare choices and generally less capable of making these choices, but they still do not actively seek out help.

The screening index, if developed further, might be used as a screening tool to help identify beneficiaries who need decision assistance. Once validated, it would be useful as a short, simple, and easily administered proxy measure for comprehension skill. The degree of diversity of functioning within the Medicare population is a key issue for shaping interventions to inform and educate these individuals and support their decisions.

Study Limitations. There is almost no work on measuring skill level in using information in decisions among older adults. Thus, this work is exploratory and preliminary. The ability to generalize the findings is limited by the use of a convenience sample. Therefore, we cannot assume that the degree of comprehension deficits found in the study population extends to the general population. However, it is unlikely that the use of a convenience sample influences the internal validity or the observed relationships among variables. Any bias introduced as a result of the sample would more likely affect the generalizability of the prevalence of comprehension deficits and less likely to affect the observed correlates of comprehension deficits (e.g., the relationship between errors made and perceived burden of decision making). Nevertheless, studies based on larger and more representative samples are needed.

The comprehension index includes only the lowest skill level in decision making; higher level tasks are not included. Further, this index does not indicate the level at which performance is adequate or inadequate. Both of these study limitations are areas that could be the focus of future work but are beyond the scope of this project. Further work that validates the screening

index and comprehension index is also needed.

Implications for Future Research. In the present study, we constructed a preliminary index of comprehension skill that appears to be both valid and reliable. The index assesses an individual's ability to interpret and understand comparative information for use in choices. Those who perform at the high error end of the comprehension index, making 30 percent or more errors, are clearly not capable of using comparative information in decision making on their own. However, where the cut-off should be (i.e., percentage of errors) is not clear. What is clear is that it is possible to measure at least this basic element of decision skill, and that the beneficiary population varies substantially at this most elemental level of decision skill.

The diversity in functioning strongly suggests a segmentation approach to educating, informing, and supporting decisions in the older population. Such an approach will need to be supported by a planned research agenda. First, more work on a measure of decision skill is needed. What are all the elements of decision skill required to make decisions about one's Medicare choices? What is an adequate level of skill? Can we develop a screening tool to achieve a higher level of accuracy? What are the best ways of communicating information to the different segments of the Medicare population? Can we, with different presentation approaches for each segment, make information more usable and used? There is a need to test different presentation approaches to make information more evaluable or usable for different segments of the population. Are there approaches that would work with the lower-skilled population? For example, would narratives or stories help beneficiaries with less skill use the information more effectively in making choices? If, instead of delivering information in charts and tables, we delivered it in a story that provides context and affect, would that be a more effective format for those beneficiaries who have difficulty using charts and tables? Would audio or video programs be more effective? What kind of decision support would be most effective for the different segments of the Medicare population?

Policy Implications

The findings show that those with less comprehension skill are more willing to delegate decisions and find making decisions and having choice more burdensome than those with higher skills do. However, those with less skill are no more likely to say they will seek help. We cannot assume that those most in need of assistance will be the ones seeking it. This presents a serious challenge to helping this population; engaging in aggressive outreach may be necessary. Screening and triaging those who do seek assistance is another approach. For example, it would be possible for State Health Insurance Program counselors, or any information intermediaries, to use the screening tool developed here for prioritizing and triaging beneficiaries who come in for help. Decision support tools could be developed and designed specifically for those with lower skills.

If we accept that a large proportion of the Medicare population will have difficulty using comparative information in choices on its own, it would seem that three directions are possible:

- Simplify the task required of beneficiaries in Medicare decisions. This could be accomplished by having fewer types of plan designs to choose from and less complexity

in the nature of the choices. Medigap choices were simplified by standardizing options, and similar approaches could be taken with Medicare+Choice. The benefit packages, cost structures, and case management mechanisms of the various Medicare options have a high level of complexity and likely are a barrier both for making choices and for navigating within a particular system.

Proposals for modernizing Medicare and stand-alone prescription drug insurance also appear to introduce more complexity into choices for beneficiaries. These proposals should be examined in light of the burden they place on beneficiaries, then adjusted to reflect realistic decision tasks for this heterogeneous population.

- Investigate ways, including nonprint approaches, to make the information easier to understand and more accessible to the lower-skilled portion of the Medicare population. We also need to examine other areas where there is a high reliance on giving information to beneficiaries to guide their decisions and behavior (e.g., clinical decisions, adherence to medical regimens), and assess its usability and ways to make it more accessible to a lower-skilled population.
- Identify those most in need and provide assistance to them. Screening the population as they seek assistance will help to ensure that those most in need will get priority in receiving assistance. However, because those who are less skilled are not more likely to seek assistance, helping them will require active outreach. The current system is not designed to reach out to beneficiaries; rather, it is set up to help those who seek out help. Outreach programs, including those directed to family members, will be needed.
- The high degree of variability in functioning suggests that strategies aimed at Medicare beneficiaries need to be tailored to skill level and not targeted to a homogeneous population. A segmentation approach to communicating with this population will be essential to achieving educational program objectives and supporting informed decisions. Identifying and estimating the size of the different segments are important initial steps in the process of tailoring information and services.

It may be prudent to pursue a strategy that includes all three of these elements. However, as we embark on policy directions that rely so heavily on giving Medicare beneficiaries more information and more choice, it is critical that we (1) understand what portion of the older population has the skills to cope successfully with the information and the choices available; (2) support that portion with appropriate information; (3) and not burden those who lack decision skills with too much information and too many choices.

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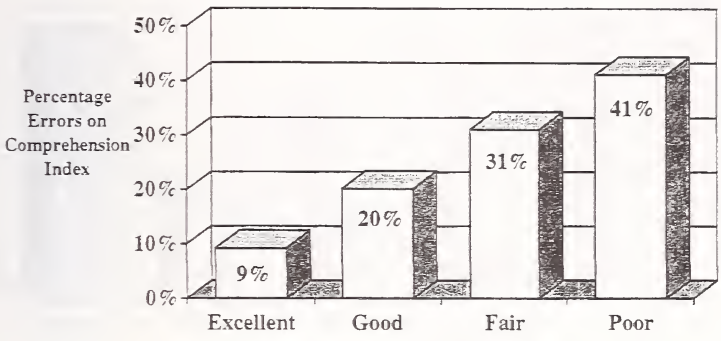
Table 1: Characteristics of the Study Population

	Study Population	N of study population	MCBS*
Age			
65 to 69	18%	44	25%
70 to 74	35%	88	27%
75 to 79	29%	72	21%
80 or more	19%	47	27%
Education			
Less than high school	9%	22	40%
High school diploma	31%	76	32%
Some college / vocational school	37%	91	14%
College graduate or more	24%	60	14%
Gender			
Female	61%	153	56%
Health			
Excellent / Very Good	44%	29 / 78	45%
Good	40%	96	30%
Fair / Poor	17%	35 / 5	25%
Income			
Less than $10,000	16%	38	30%
$10,000 to $19,999	34%	82	30%
$20,000 to $39,999	34%	81	29%
$40,000 to $59,999	11%	26	5%
$60,000 or more	5%	13	6%
Marital Status			
Married	54%	135	56%
Total		253	

* 1995 Medicare Current Beneficiary Survey

Figure 1: Comprehension Score by Self-Assessed Skill in Using Tables and Graphs

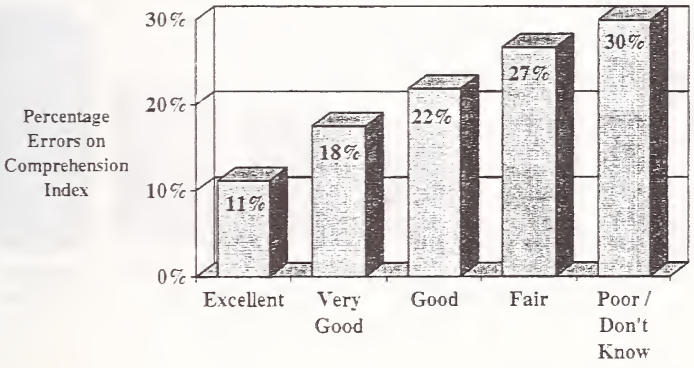
Average percentage of errors by "How would you rate your skill in using information from tables and charts to make decisions?"



$r = -.37$, $p < .001$, $n = 228$

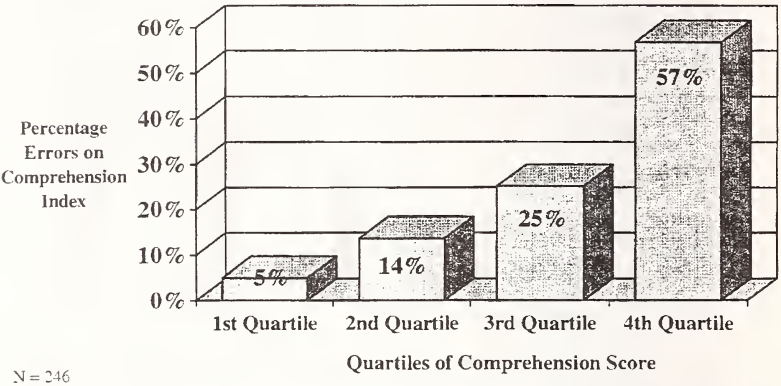
Figure 2: Comprehension Score by Self-Reported Understanding of the Difference Between Medicare HMOs and Original Medicare

Average percentage of errors by "How well do you understand the difference between Medicare HMOs and original Medicare?"



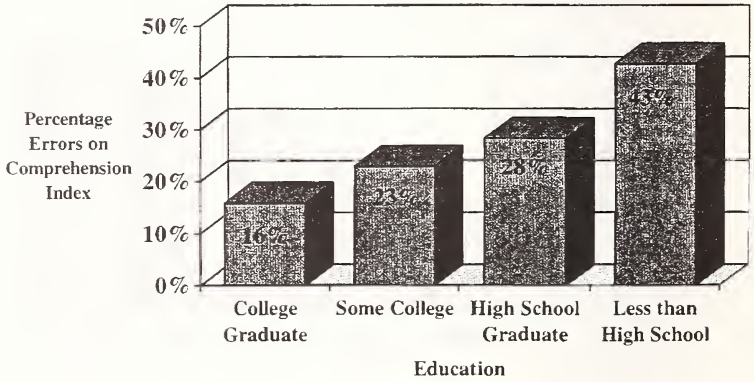
$r = .23$, $p < .001$, $n = 243$

Figure 3: How Participants Are Distributed on Comprehension Score
Average percentage of errors by respondents in the four quartiles of the comprehension index



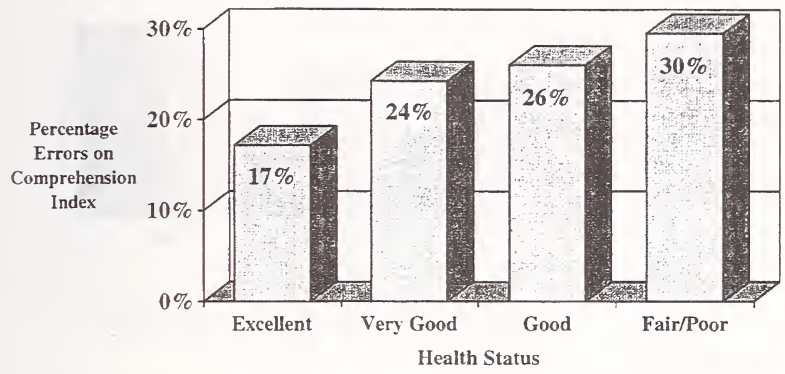
N = 246

Figure 4: What Factors Are Related to Comprehension Score? Education
Average percentage of errors by education



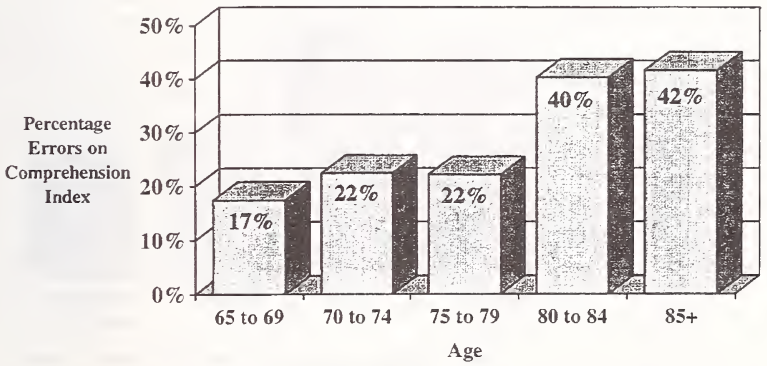
r = -.33, p < .001, n = 243

Figure 5: What Factors Are Related to Comprehension Score? Health Status
Average percentage of errors by self-reported health status



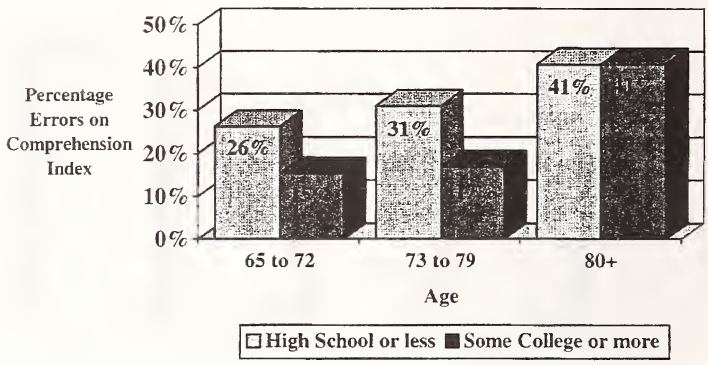
r = .15, p < .05, n = 237

Figure 6: What Factors Are Related to Comprehension Score? Age
Average percentage of errors by age



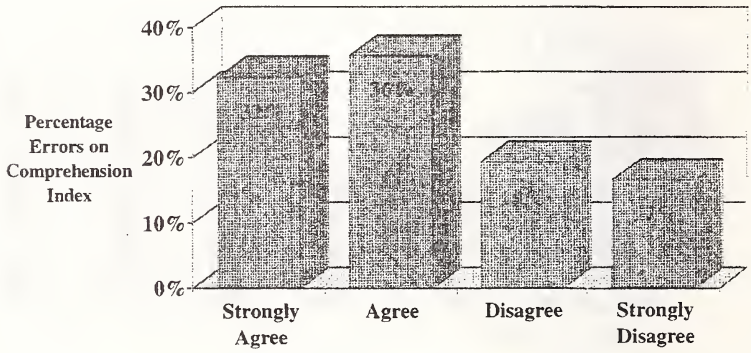
r = .32, p < .001, n = 245

Figure 7: Effect of Education on Comprehension Score Decreases with Age.



n = 244

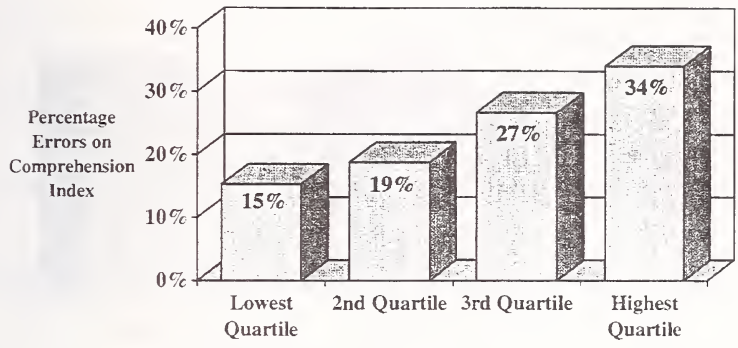
Figure 8: Those Who Want to Delegate Decision Have Lower Comprehension Scores. Average percentage of errors by "When choosing a Medicare health plan, instead of choosing myself, I'd rather have an expert tell me which Medicare plan is best."



r = .32, p < .001, n = 243

Figure 9: Those Who View Medicare Decisions As Burdensome Have Lower Comprehension Scores.

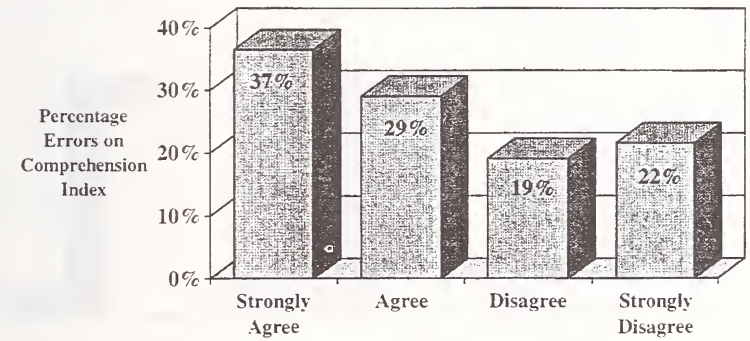
Average percentage of errors by Burden Index



r = .35, p < .001, n = 234

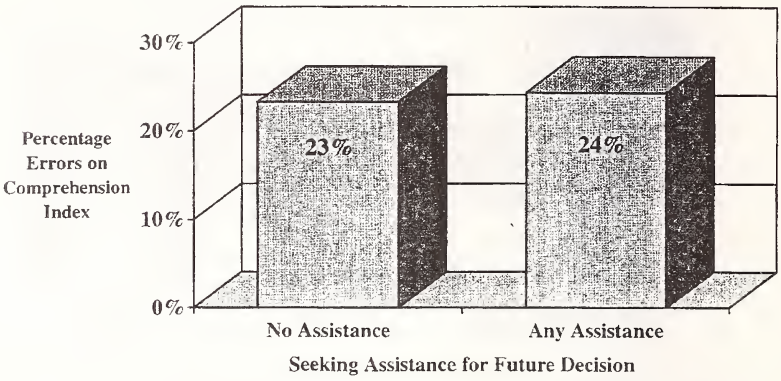
Figure 10: Those Who Want Help from Family or Friends Making the Decision Have Lower Comprehension Scores.

Average percentage of errors by "Instead of choosing myself, I'd rather have a family member or close friend help me decide which Medicare plan to choose."



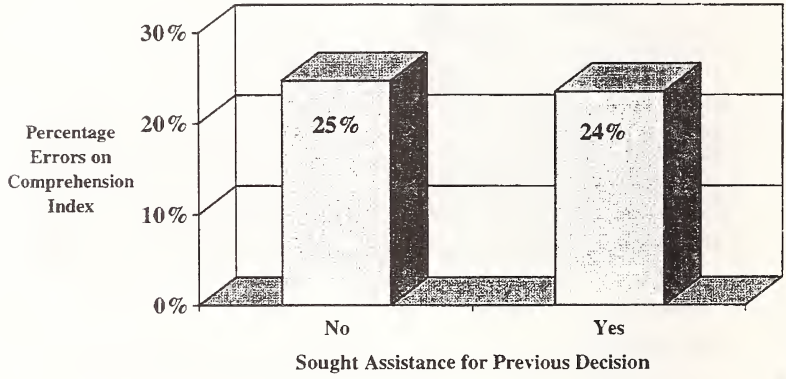
r = .23, p < .001 n = 244

Figure 11: Seeking Assistance Is Unrelated to Comprehension Scores.
Average percentage of errors by "If you had to make a choice of a Medicare health plan in the coming year, how much assistance would you seek in making that choice?"



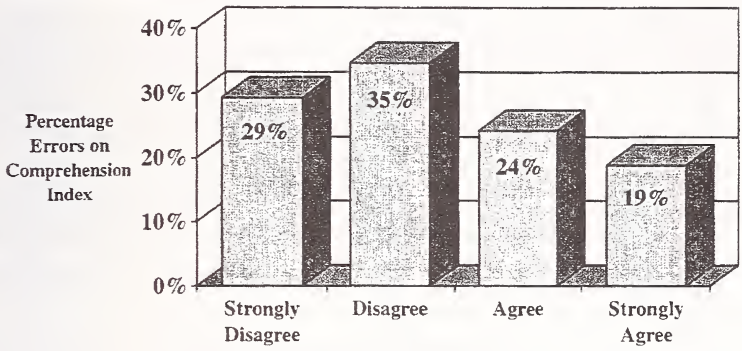
p = .67, n = 239

Figure 12: Assistance Sought Is Unrelated to Comprehension Scores.
Average percentage of errors by "Have you ever sought assistance when you needed to choose a Medicare plan?"



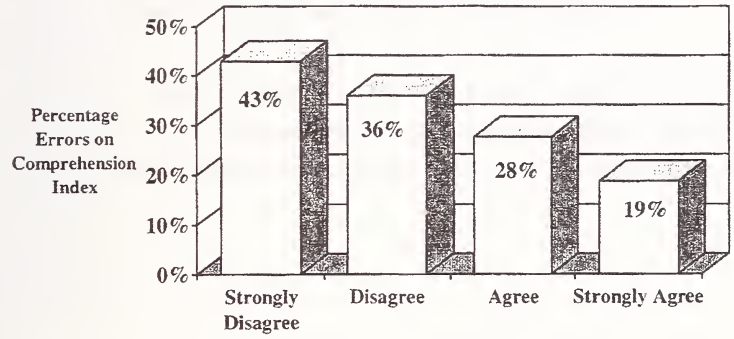
p = .70, n = 238

Figure 13: Those Who Want More Choices Have Higher Comprehension Scores.
Average percentage of errors by "I am more likely to make a good choice if I have lots of different options to choose from."



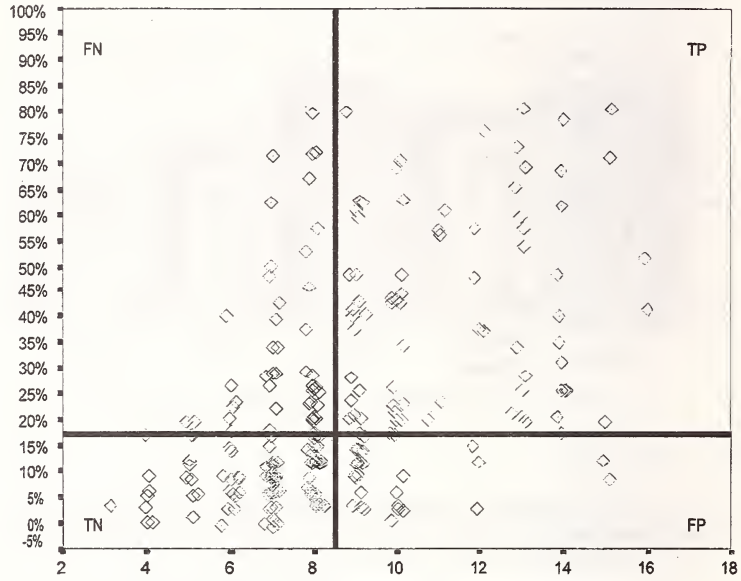
$r = .22$, $p < .001$, $n = 243$

Figure 14: Those Who Desire More Information Have Higher Comprehension Scores.
Average percentage of errors by "When choosing a Medicare health plan, I prefer to have lots of information about each Medicare health plan choice."



$r = .30$, $p < .001$, $n = 245$

Figure 15: Scatter Plot: Sample Distribution on Screening Index and Comprehension Score



The vertical line indicates the median screening score for the study sample.

The horizontal line indicates the median comprehension index score.

KEY: FN False Negative, TN True Negative, TP True Positive, FP False Positive

Figure 16: Calculations for Estimating Score on the Comprehension Index in the Larger Beneficiary Population

False Negatives = 12%	True Positives = 44%
[37% of MCBS sample has a low screening score] x [33% of study population with a low screening score has a high error rate] = 12%	[63% of MCBS sample has a high screening score] x [70% of study population with a high screening score has a high error rate] = 44%
False Negatives = (.37 x .33 = .12)	True Positives = (.63 x .70 = .44)
True Negatives = 25%	**False Positives = 19%**
[37% of MCBS sample has a low screening score] x [67% of study population with a low screening score has a low error rate] = 25%	[63% of MCBS sample has a high screening score] x [33% of study population with a high screening score has a low error rate] = 19%
True Negatives = (.37 x .67 = .25).	False Positives = (.63 x .30 = .19)

Source: Medicare Current Beneficiary Survey, 1995

High screening scores are defined as greater than the median score (8) for the screening index within the study population. Low scores are those that are less than or equal to the median.

High error rates are defined as being greater than the median percentage of errors (17%) for the study population. Low scores are those that are less than or equal to the median.

Appendix A: Attitudes about managed care and choice

For these first questions, we are interested in your opinions. There are no right or wrong answers.

1. **How much do you agree or disagree with each of the following statements?** Mark one box on each line.) (Strongly disagree, Disagree, Agree, Strongly Agree

   a. In general, the quality of medical care that people on Medicare get in an HMO is worse than the care that people get who have traditional Medicare.

   b. In general, the more expensive the monthly premiums are for a health plan, the higher the quality of medical care is.

   c. Health plans are all about the same in terms of how good the medical care is.

2. **If you had to make a choice today, how hard or easy would it be to decide which Medicare health plan to enroll in?** (Very Hard, Hard, Easy, Very easy)

3. **If you made a bad choice when selecting a Medicare health plan, how serious a problem would that be for you?** (Not a problem, A small problem, A medium problem, A large problem

4. **Have you ever asked for help in choosing a Medicare health insurance plan from a group or organization that provides health insurance counseling?** (Yes, No)

5. **Is there a service in the Eugene-Springfield area that offers free counseling to people on Medicare about choosing a health insurance plan?** (Yes, No)

6. **The last time you chose a Medicare health plan, did you seek assistance to help you choose?** (Yes, No)

IF YES

7. **Who did you seek assistance from? (Mark all that apply):**
   a. A health insurance program counselor
   b. A health plan
   c. A physician
   d. Employer or benefits manager
   e. An insurance salesman or broker
   f. Consumer group, (e.g., consumer reports)
   g. A pharmacist
   h. A Family member
   i. A Friend
   j. An 800 Medicare telephone help-line
   k. An Internet Web site

8. **Assuming you have to make a choice of a Medicare health plan in the coming year, how much assistance are you likely to seek in making that choice?** (No assistance, A minimal amount of assistance, A moderate amount of assistance, A lot of assistance)
9. **Considering all the information that you saw or heard during the past six months, how would you rate your understanding of the different types of health insurance plans for people on Medicare? Would you say your understanding is** (Poor, Fair, Good, Very good, Excellent)
10. **How much do you agree or disagree with the following statements?** (Strongly disagree, Disagree, Agree, Strongly agree)

    (a) I prefer to not have the responsibility for choosing.
    (b) I prefer to have lots of information about each Medicare health plan choice.....
    (c) I am more likely to make a wrong choice if I have lots of different options to choose from.
    (d) I am more likely to make a good choice if I have lots of different options to choose from.
    (e) I prefer to have someone knowledgeable help me decide among the options.
    (f) I prefer to choose a Medicare health plan without help from anyone.
    (g) Choosing a Medicare health plan is a task I would rather avoid.
    (h) I often feel overwhelmed because there is too much information about each health plan to take in
    (i) I have difficulty understanding all the information about each Medicare health plan.
    (j) Whenever I make a choice, I worry it will be the wrong one.
    (k) Instead of choosing myself, I'd rather have an expert tell me which Medicare plan is best.
    (l) Instead of choosing myself, I'd rather have a family member or close friend help me decide which Medicare plan to choose.
11. **How would you *rate your skill in using information from tables and charts* to make decisions? Would you say your skill is...** (Poor, Fair, Good, Excellent)

Appendix B: Health and Demographics

YOUR HEALTH AND HEALTH CARE

1. **In general, would you say your health is**...(Excellent, Very good, Good, Fair, Poor

2. **About how many times have you visited a doctor or nurse in the last month? Please include any visits you made to a doctor's office, community clinic, or emergency room. Do not include hospital overnight stays or dental visits.**_____

3. **How many nights did you stay overnight as a patient in the hospital in the past year**_____

4. **How many different prescription medicines do you take on a regular basis**____

5. **Has a doctor or nurse told you that you have any of the following health problems?** ***(Mark all that apply.)*** (High blood pressure, High cholesterol, Arthritis, Chronic back pain or sciatica, Cancer, Heart disease, Diabetes, Depression, Asthma, Chronic Bronchitis)

DEMOGRAPHICS

1. **What is your date of birth?**

2. **Are you male or female?**

3. **Are you currently living alone?**

4. **What is your marital status** (Single, Married, Divorced, Widowed)

5. **Are you of Hispanic or Latino background?**

6. **How would you describe your race?** (Check all that apply) (American Indian or Alaskan Native, Asian or Pacific Islander, Black/African American, White/Caucasian, Another race SPECIFY:_____)

7. **What is the highest grade you completed in school?** (Check one) (8th grade or less, Some high school, but did not graduate, High school graduate or GED, Vocational or trade school, Some college or 2-year degree, 4-year college graduate, More than 4-year college degree.)

9. **What is your current employment status?** (Retired, Working full time, Working part time)

10. **How satisfied are you with your current Medicare plan?** (Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied)

11. **Which of the following categories best describes your household's total income before taxes last year? Please include income from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources.** (Less than $10,000, $10,000 - $19,999, $20,000 - $39, 999, $40,000- $59,999, $60,000 - $79,999, $80,000 or more)

HEALTH PLAN TYPE

"Medicare is a program that provides health insurance for citizens 65 years or older. The traditional Medicare plan covers things like doctors visits, lab tests, x-rays and hospital stays. It works pretty much like any health insurance policy. Some people choose to enroll in an HMO instead of the traditional Medicare plan. Then they get all their medical care from that Medicare HMO. Medicare helps pay for their HMO enrollment."

1. Do you have traditional Medicare or do you have a Medicare HMO plan? (Traditional Medicare, Medicare HMO, Both, Don't know)

   1a. If you decided on your own to go to a doctor who was not part of your Medicare HMO, would the HMO still pay part of the bill?

2.. Do you have a supplement or Medigap policy? (Yes, No)

   2a. For that supplement or Medigap policy, do you have to choose doctors from an approved list, or can you see any doctor you want?

Appendix C: Summary of comprehension measures

A. Pick the Best, Seven tasks selecting the best health plan from among five plans. Format: Tables only 29

B. Pick the Best with different versions, Fifteen tasks to select the best health plan from among three, five, or fifteen plans. Format: Tables only, Tables with stars, Bar-Charts only, or Bar-Charts with stars 30-32

C. Comprehension test from available information experiment: Five tasks of reading tables and making inferences 33-35

D. Trend comprehension tasks. Three questions to assess ability to interpret the table: One version with explicit trend and cost 36

E. Ordered Health Plan Choices: Pick three preferred plans based on cost and satisfaction. Non-optimal choices include preferring a plan that scores lower on satisfaction than another plan within the same cost stratum. 37-38

Index	Experiment	Description	Range
	A	Pick the Best	0-7
	B	Pick the Best, Versions	0-15
	C	Comprehension from available information	0-5
	D	Trend comprehension	0-3
	E	Ordering	0-3
Comprehension 1	A + C + D	Sum of tasks in which all respondents received the same information	0-15
Full Comprehension	A + B + C + D + E	Sum of all tasks	0-33

A. Pick the Best:

Satisfaction with HMO

HMO members rated their HMO on a survey question asking: All things considered, how satisfied are you with your current HMO?"

Given the information below, which plan would you choose? (check 1 box)

Item 1	*Percentage of members who were:*			
Check one box	Dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very or completely satisfied
❑ Plan A	16%	7%	30%	47%
❑ Plan B	10%	7%	27%	56%
❑ Plan C	20%	6%	31%	43%
❑ Plan D	14%	4%	24%	57%
❑ Plan E	7%	4%	20%	69%

B. Pick the Best with Different Versions: Version 1 (Table only):

Satisfaction with HMO

HMO members rated their HMO on a survey question asking: All things considered, how satisfied are you with your current HMO?"

Given the information below, which plan would you choose? (check 1 box)

Item 1	*Percentage of members who were:*			
Check one box	Dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very or completely satisfied
❑ Plan A	16%	7%	30%	47%
❑ Plan B	10%	7%	27%	56%
❑ Plan C	20%	6%	31%	43%

Version 2 (Table with Stars):

Satisfaction with HMO

HMO members rated their HMO on a survey question asking: All things considered, how satisfied are you with your current HMO?"

The stars tell which plans did:

★★★ better than most other plans,

★★ about the same as most other plans, or

★ worse than most other plans.

Given the information below, which plan would you choose? (check 1 box)

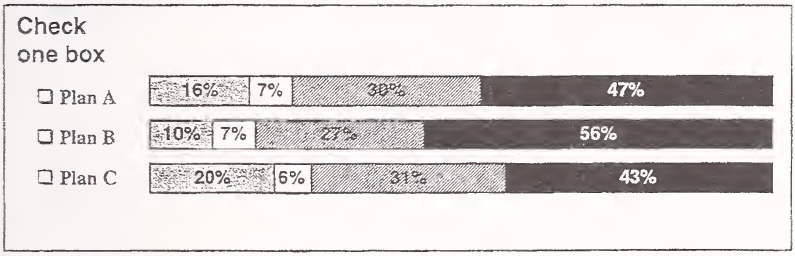
Item 1		*Percentage of members who were:*			
	Check one box	Dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very or completely satisfied
★	❑ Plan A	16%	7%	30%	47%
★★★	❑ Plan B	10%	7%	27%	56%
★	❑ Plan C	20%	6%	31%	43%

B. Pick the Best with Versions: Version 3 (Bar-Charts only):

Satisfaction with HMO

HMO members rated their HMO on a survey question asking: All things considered, how satisfied are you with your current HMO?"

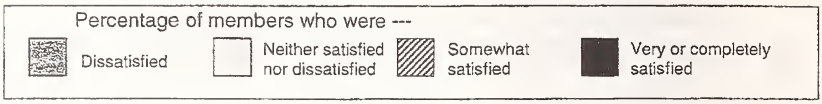
Item 1: Given the information below, which plan would you choose? (check 1 box)



B. Pick the Best with Versions: Version 4 (Bar-Charts with Stars)

Satisfaction with HMO

HMO members rated their HMO on a survey question asking: All things considered, how satisfied are you with your current HMO?"



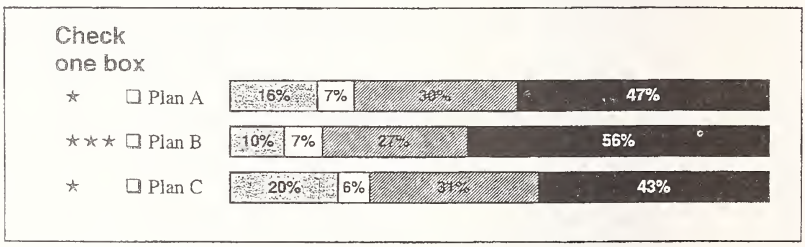
The star symbols to the left of each plan tell how each health plan compares to the survey average for all plans. The survey average for a topic is based on the answers from all people surveyed in all the health plans. The stars only tell which plans did:

★★★ better than most other plans,

★★ about the same as most other plans, or

★ worse than most other plans.

Item 1: Given the information below, which plan would you choose? (check 1 box)



C. Comprehension Test from Available Information Experiment:

Understanding HMOs

A. Consider the information about an HMO present below, and answer the following questions. (Note that all the information required to answer the questions is available in the table.)

1999 monthly premium	$100
Annual premium increase	2.0%
Benefits	
In-hospital services	No co-payment
Office visits	$10 co-payment
Treatment Quality Indicators	
Members "very satisfied" with physician access	41%
Members "very satisfied" with availability of preventive care (e.g. immunizations)	39%

1. What percentage of members are "very satisfied" with physician access? (Circle only one response.)

a) 100%

b) 2%

c) 41%

d) 39%

2. In the year 2000, this HMO's monthly premium will be: (Circle only one response.)

a) $98

b) $100

c) $102

d) $120

C. Comprehension Test from Available Information Experiment: (cont)

Which HMO?

	Member Satisfaction	Preventive Care Strategies	Access to Specialists	Customer Service	Premium
HMO A	★★★	★★	★★★	★	$60
HMO B	★	★★★	★★	★★	$60
HMO C	★★★	★★	★	★★★	$60

★= Below Average ★★ = Average ★★★ = Above Average

David doesn't want any HMO that is below average on member satisfaction. He also doesn't want any HMO below average on access to specialists.

Which HMO will David choose? (Check one box).

❑ HMO A

❑ HMO B

❑ HMO C

C. Comprehension Test from Available Information Experiment: (cont)

Understanding HMOs

B. Consider the information about four HMOs presented below, and answer the following questions. (Note that all the information required to answer the questions is available in the table.)

	HMO A	HMO B	HMO C	HMO D
Monthly Premium	$50	$75	$48	$63
Copayment for office visit with primary care doctor	$10	$5	$15	$10
Percentage of members "very satisfied" with treatment quality	38%	34%	28%	38%
Percentage of members "very dissatisfied with treatment quality	12%	14%	10%	10%

1. Which HMO requires the lowest copayment for a visit with a primary care doctor? (Circle only **one** response)

   (a) HMO A

   (b) HMO B

   (c) HMO C

   (d) HMO D

2. Which HMO provides the best treatment quality according to the members' ratings? (Circle only **one** response)

   (a) HMO A

   (b) HMO B

   (c) HMO C

   (d) HMO D

D. Trend Comprehension Test

HMO Trend Choice – III

Please imagine that each year you need to compare and choose between two HMOs. This year you HMO choices differ only in cost and member satisfaction with the quality of care received.

How to compare HMO scores:

An HMO can score from 0 to 100. Both of the plans below are considered to be relatively good. HMO scores that are fewer than three points apart may not show real differences.

	Member satisfaction with quality of care					Monthly premiums
	In past years:				**This year:**	**This year:**
	1995	1996	1997	1998	**1999**	**1999**
HMO plan C score	67	68	68.5	70	**71**	**$55**
(% change from previous year)		+1.5%	+0.7%	+2.2%	+1.4%	
HMO plan D score	81	80	78	77	**76**	**$70**
(% change from previous year)		-1.2%	-2.5%	-1.3%	-1.3%	

1. Based on the information above, has member satisfaction with quality of care in recent years (please check one box);

   ☐$_1$ Gone **up** in Plan C and **down** in Plan D

   ☐$_2$ Gone **down** in Plan C and **up** in Plan D, *or*

   ☐$_3$ Stayed the **same** in both Plan C and Plan D

2. Based on the information above, is member satisfaction with quality of care currently higher in (please check one box);

   ☐$_1$ Plan C, *or*

   ☐$_2$ Plan D

3. Based on the information above, which plan costs more each month?

   ☐$_1$ Plan C, *or*

   ☐$_2$ Plan D

E. Ordered Health Plan Choices: Form A

Below are 15 health plans. For each plan you have (a) the monthly cost to be paid by you (above the cost paid by your employer) and (b) the distribution of member ratings on the question "All things considered, how satisfied are you with your current HMO?"

Please examine this information carefully and indicate your first, second, and third preferences by placing a 1, 2, or 3 in the space to the left of the three plans you select.

Mark preferred plans 1, 2, and 3 below	Cost	*Percentage of members who were:*			
		Dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very or completely satisfied
____ Plan E	$100	7%	4%	20%	69%
____ Plan H	$100	13%	5%	20%	61%
____ Plan B	$100	10%	7%	27%	56%
____ Plan J	$100	12%	5%	25%	58%
____ Plan K	$100	14%	5%	22%	58%
____ Plan D	$75	14%	4%	24%	57%
____ Plan F	$75	14%	7%	25%	55%
____ Plan I	$75	13%	8%	26%	54%
____ Plan N	$75	13%	7%	27%	53%
____ Plan G	$75	17%	6%	25%	53%
____ Plan M	$50	16%	7%	26%	51%
____ Plan A	$50	16%	7%	30%	47%
____ Plan C	$50	20%	6%	31%	43%
____ Plan O	$50	20%	10%	31%	39%
____ Plan L	$50	22%	11%	31%	36%

E. Ordered Health Plan Choices (cont): Form B

Below are 15 health plans. For each plan you have (a) the monthly cost to be paid by you (above the cost paid by your employer) and (b) the distribution of member ratings on the question "All things considered, how satisfied are you with your current HMO?"

Please examine this information carefully and indicate your first, second, and third preferences by placing a 1, 2, or 3 in the space to the left of the three plans you select.

Mark preferred plans 1, 2, and 3 below	Cost	*Percentage of members who were:*			
		Dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very or completely satisfied
____ Plan A	$50	16%	7%	30%	47%
____ Plan B	$100	10%	7%	27%	56%
____ Plan C	$50	20%	6%	31%	43%
____ Plan D	$75	14%	4%	24%	57%
____ Plan E	$100	7%	4%	20%	69%
____ Plan F	$75	14%	7%	25%	55%
____ Plan G	$75	17%	6%	25%	53%
____ Plan H	$100	13%	5%	20%	61%
____ Plan I	$75	13%	8%	26%	54%
____ Plan J	$100	12%	5%	25%	58%
____ Plan K	$100	14%	5%	22%	58%
____ Plan L	$50	22%	11%	31%	36%
____ Plan M	$50	16%	7%	26%	51%
____ Plan N	$75	13%	7%	27%	53%
____ Plan O	$50	20%	10%	31%	39%

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON

Chairman Baucus, Senator Grassley, distinguished members of the Committee, it's a pleasure to be with you. I appreciate the Committee's excellent work on so many issues important to our economy and to the lives of people across our country. And I welcome the opportunity of appearing before you to talk about what we're doing at the Department of Health and Human Services to make our department more capable of fulfilling the mission our name describes service to people who need help.

Today, I'm going to discuss changes we're bringing to the Centers for Medicare and Medicaid Services, or CMS—formerly known as the Health Care Financing Administration, or HCFA. But I want to set my remarks about the Centers in a broader context. The transformation of the Centers is part of a larger effort to renew my Department, to make it more efficient so that it can be more effective.

We are taking aggressive steps toward bringing a culture of responsiveness to HHS. This culture, this spirit, is rooted in a commitment to compassion and a call to responsibility. We intend to reinvigorate the entire department with a spirit of responsiveness to our constituents to you, members of Congress; to our colleagues in government, here in Washington and throughout the nation; and to those who really are our most important constituents, the men and women and children we serve. And we intend to answer our call to serve our constituents with a deepened sense of responsibility and a heightened sense of mission.

Too often, we've had to deal with an attitude that says, "This is the ways it's always been. It's the best we can do." I reject that attitude completely. HHS is a wonderful department staffed by thousands of dedicated public servants. Yet it's human nature to accept the status quo. So, I've sent a clear message—accepting mediocrity runs counter to our duty as servants of the public's interests and the public's trust. Our constituents, the American people, deserve better. Under the new spirit we're bringing to HHS, they will have better.

One of the first thing's we've done is to demand a renewed dedication to answering people when they need help. When physicians call us, when ordinary people write us, when other agencies ask for help and when people like you in the Senate or the House have questions and concerns, we need to respond quickly, thoroughly and accurately. The days of long delays, unintelligible answers and inadequate assistance are over. To that end, we've established a new protocol for responding to requests for help and information. As a first step, the HHS Executive Secretariat has been charged with clearing away all backlogged correspondence by July 1. I've directed that an answer to any letter for my signature must be on my desk within 15 business days of the time it arrives in my office. Frankly, I think even that's too long. But at least it sets a deadline for accountability. We are also moving toward a paperless system to speed up our response time. And I've insisted that all written material be expressed in plain, understandable English. If we can perform cross-continental surgery using satellite technology and electronic data transfer, we can write a simple English sentence that anyone can understand.

Responsiveness must extend to states, as well. As all of you know, I was a governor for 14 years. From my own experience, I know the frustration of trying to get help from Washington. Let me emphasize that the difficulty lies not with any one group of individuals but with a system that sometimes seems to put nicely filled-out forms ahead of pressing human needs. Of course, there is a genuine need for some rules. But rules should exist to help, not hinder, our efforts to assist hurting people. When regulations, mandates and paperwork obscure or even thwart the help we are called to provide, those rules need to be changed.

In the past four months, I've approved more than 600 Medicaid and SCHIP waivers and State Plan Amendments. I have authorized these changes because people with immediate needs cannot wait for a rumbling bureaucracy to plod along. They need help when they need it and in most cases, that means not at some distant point in the future, but now.

We must give states the flexibility to develop Medicaid and SCHIP programs that suit their needs and we must speed approval of their innovative ideas and solutions. As is indicated by the number of waivers and State Plan Amendments I have approved, we have already made significant progress in this area, but we know there is much more to be done. Since I became Secretary, we have reengineered the Medicaid waiver process with a focus on "getting to yes." We are working with states to be more responsive and timely in our decision-making on waivers and amendments, to encourage innovation by the states and to grant speedy approval for "look-alike" waivers. We are also cleaning-up the backlog of State Plan Amendments, now have a new database in place to track the status of state waiver requests and are fostering a new culture at CMS of giving states an answer—period. Of course, we

would like the answer to be "Yes," but whatever the answer, we must foster a culture of deciding and of answering even if the answer is "No."

In addition, we're forming a new regulatory reform group that will look for regulations that prevent physicians and other health care providers from helping people in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined and what rules need to be cut altogether.

Within HHS, we must solve our own technology problems. For example, HHS currently is home to nearly 1,200 different computer systems, most of which can't talk to one another. There are 981 toll free numbers, hundreds of computer rooms and many of individual agency support services, such as help desks. In one department office, we have five financial management systems, 13 grants management systems, six acquisition management systems, six personnel systems and 13 email systems. As one might guess, they have difficulty communicating with one another since there is no common infrastructure. When I arrived at HHS and learned about this, it seemed to me that this was very much like a city in which every block had its own power plant and its own telephone company.

In the short time I've been in HHS, I've taken a number of steps to start making sense of all of this. First, I am determined that HHS Information Technology will be managed on an enterprise basis with a common infrastructure, rather than by many separate agencies.

I will establish the HHS Chief Information Officer with authority over HHS information technology resources with the charge to implement a "One Department," one-enterprise approach to information technology. I've recently decided that HHS will have one financial management system for CMS. It's called HIGLAS, and I will describe it in a moment. There will be another management system for the rest of the department. And I have decided that HHS will have one personnel system.

So, the transformation of the Department of Health and Human Services has begun. It will take time and will demand some expenditure. But it can be done, and it will be done.

There is no place where that transformation is more critical than in the agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Administrator Tom Scully and I are committed to ensuring these programs are more responsive to our provider partners, the States, and the millions of Americans who depend on them. We intend to work with this Committee and with Congress in a bipartisan fashion to accomplish our objectives, so that these critical programs are prepared to meet not only today's needs, but also tomorrow's challenges.

BACKGROUND

CMS is the nation's largest health insurer, providing coverage to more than 70 million Americans. This year alone the Medicare, Medicaid, and SCHIP programs will pay an estimated $476 billion in benefits. CMS has one of the largest budgets of any federal agency or Department. Each year Medicare alone processes nearly one billion claims from over one million physicians and other health care providers.

The Medicare and Medicaid programs have been the center of our society's commitment to protect the low-income and ensure that all of our seniors enjoy a healthy and secure retirement. Honoring this commitment means making sure that the Medicare program is financially prepared for new beneficiaries, and ensuring that current beneficiaries have access to the highest quality care. And it means ensuring that States are afforded flexibility to meet the needs of their citizens. It also means changing the way the CMS does business, improving its relationship with its business partners, and taking bold action to modernize its programs for the future. As Tom Scully and I announced last week, we have made several important management improvements to CMS. I will discuss these and other changes in greater detail in my testimony today and also highlight future objectives that I hope we can accomplish together during this Congress.

NEW AGENCY NAME AND STRUCTURE

Last week, we announced our plans to rename the Health Care Financing Administration and call it the Centers for Medicare and Medicaid Services. The department asked a variety of sources for suggestions and reactions to the proposed names, including seniors, the Agency's provider partners, State Health Insurance Assistance Programs, and State Medicaid Directors. We conducted extensive focus group testing. We even set up a contest for our employees to offer suggestions. This change is more than cosmetic. It represents a new openness and a new atmosphere at CMS. It also better reflects the Agency's mission to serve Medicare and Medicaid

beneficiaries and it makes it clear to the Americans, who rely on these programs, that the CMS is responsible for administering these programs. All the focus groups said, "What is HCFA?" and "Medicare and Medicaid should be in the name." So, we did what they suggested. In addition to the name-change, several constructive organizational changes were also announced. The Agency has been reorganized and simplified around three centers that better represent the Agency's major lines of business. These core centers will give beneficiaries, States, physicians and other providers a clear and direct point of contact within the Agency for information on policies and programmatic changes that impact them. The three core centers are as follows:

- The Center for Beneficiary Choices will focus on educating beneficiaries about their health care choices. From traditional fee-for-service and Medigap, to Medicare Select and Medicare+Choice, beneficiaries too often do not understand their options and we are determined to change that. The Center also will be responsible for managing the Medicare+Choice plans, conducting consumer research and demonstration programs, providing beneficiary education, as well as overseeing beneficiary grievance and appeals processes.
- The Center for Medicare Management will be responsible for managing the traditional fee-for-service Medicare program. The center will develop and oversee the Agency's fee-for-service payment policies and manage the Medicare fee-for-service contractors. These functions are over 85 percent of Medicare program operations and represent CMS's largest functions.
- The Center for Medicaid and State Operations will be primarily responsible for programs administered by the States. The center will work in partnership with the States in administering the Medicaid and SCHIP programs, as well as overseeing insurance regulatory activities, survey and certification, and clinical laboratories. The profile of the center will be raised, so will its responsiveness to States.

IMPROVING AND EXPANDING EDUCATION

In the next few months, we also will launch an aggressive new education campaign to ensure that all Medicare beneficiaries understand the program, their coverage options, and the costs associated with the health care decisions they may make. We know from our polling and focus groups that far too many Medicare beneficiaries have a limited understanding of the Medicare program in general, as well as their Medigap, Medicare Select, and Medicare+Choice options. We firmly believe that CMS must improve and enhance its existing outreach and education efforts so that beneficiaries understand their health care options. In addition, CMS will tailor its educational information so that it more accurately reflects the health care delivery systems and choices available in beneficiaries' local areas. We know that educating beneficiaries and providing them more information is vital to improving health care and patient outcomes. With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, the CMS will expand and improve the existing *Medicare & You* educational campaign. For example, CMS is:

- Initiating a Multimedia Education Campaign to raise awareness among Medicare beneficiaries of their health care options. The Agency will use major television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers.
- Increasing the Capacity of Medicare's Toll-Free Lines so that the new wave of callers to 1–800–MEDICARE generated by the advertising campaign receives comprehensive information about the health plan options that are available in their specific area. By October 2001, the operating hours of the toll-free lines will be expanded and made available to beneficiaries, their families, and caregivers 24 hours a day, seven days a week. The information available by phone also will be significantly enhanced, so that specific information about the health plan choices available to beneficiaries in their state, county, city, or town can be obtained and questions about specific options, as well as costs associated with those options, can be answered. Call center representatives will be able to help callers walk-through their health plan choices step-by-step and obtain immediate information about the choices that best meet the beneficiary's needs. For example, a caller from Bozeman, Montana could call 1–800–MEDICARE and discuss specific Medigap options in Montana. Likewise, a caller from Des Moines, Iowa or Dallas, Texas could call and get options and costs for Medigap or Medicare+Choice alternatives. If requested, the call centers will follow-up by mailing a copy of the information discussed after the call.

- Improving Internet Access to Comparative Information and providing new decision making support tools on the Agency's excellent website, www.medicare.gov. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as *Nursing Home Compare and ESRD Compare* websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State-based comparative information on Medigap options and costs.

CREATING A CULTURE OF RESPONSIVENESS

One of my top priorities, as Secretary and I know one of Tom Scully's top priorities, is to improve the CMS's responsiveness. The concerns and interests of beneficiaries and the Agency's provider, plan, State, and Congressional partners clearly deserve greater attention and focus. And we are committed to addressing this head-on and fostering a new culture at CMS. The Agency is:

- Eliminating Regulatory Red Tape for the plans, providers, and other stakeholders who provide services to Medicare beneficiaries. Far too many of our partners have raised concerns about the extent of the Medicare program's regulatory burden and the cost of doing business with Medicare. I am committed to taking swift action to reduce unnecessary burden and complexity. We need to streamline Medicare's requirements, bring openness and responsiveness into the process, and ensure that regulatory changes are sensible and predictable.
- Establishing Key Contacts for the States at the regional and central office level. These staff will work directly with the States to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State will have one Medicaid staff assigned to them in the regions and another in Baltimore, who will be accountable for their specific issues. I have attached a list of these contacts to my testimony.
- Creating Primary Contacts for beneficiary groups, plans, physicians, providers, and suppliers to strengthen communication and information sharing between stakeholders and the Agency. CMS will designate a senior-level staff member as the principal point-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The designees will help ensure that industry groups' voices are heard within CMS.
- Enhancing Outreach and Education to providers, plans, and practitioners by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. The Agency will provide improved training on new program requirements and payment system changes, increase the number of satellite broadcasts available to industry groups, and make greater use of web-based information and learning systems.
- Responding More Rapidly and Appropriately to Congress and External Partners by promptly responding to Congressional inquiries. The Agency also is exploring ways to make data, information, and trend analyses more readily available to the Agency's partners and the public in a timely manner. In addition, the Agency will make explicit and widely publicize the requirements for obtaining data and analyses from the Agency, including protecting the confidentiality of the data. I have attached to my testimony a copy of a detailed response to a letter from Representatives Nancy Johnson and Pete Stark, which posed a series of questions I know many of you have asked of Tom Scully and me. I think this response, which was completed within two weeks of Tom's arrival, is indicative of this new culture at the Department and CMS. We are committed to responding promptly to Congressional inquiries.

ADMINISTRATIVE REFORM

Contracting Reform

Since 1965, when Medicare was created, the government has relied on private health insurance company contractors to process claims and perform related administrative services. Today, CMS relies on 49 contractors to provide these services. In May, I moved my office to CMS headquarters in Baltimore to get a firsthand look

at the employees, operations, and programs administered by CMS. Of the extensive technical briefings I received from the Agency staff that week, none was more eye opening than the briefing on the Agency's fee-for-service contractors. I was stunned at the way these contractor arrangements work it is one of the worst remnants of Medicare's original 1965 design. I came away from that meeting convinced that we must take bold action to reform the current contracting system and I want to work with this Committee to achieve this important objective.

In order to manage the Medicare program efficiently and effectively, we must change the Centers for Medicare and Medicaid Services' relationship with the Medicare fee-for-service contractors. I firmly believe that this work should be awarded competitively to the best-qualified entities using performance-based service contracts that include appropriate payment methodologies that result in contracts receiving payment when they deliver something of value and profit only when they perform at or above the satisfactory level. We must be able to maximize economies of scale and improve the level of service to our beneficiaries and providers. We would like to work cooperatively with our existing contractors to get to this goal but the changes will require legislative action.

Today, the fee-for-service contractors are governed by Medicare laws that impose outdated requirements and diverge from general federal acquisition laws in several respects. The Medicare statute restricts the Secretary as to the types of entities that may administer Medicare claims. On the Part A side, providers nominate the entity that processes their claims. For Part B, the program must use health insurers to process claims. We intend to forward legislation to address these differences and we want to work with this Committee and Congress on a viable, sensible solution.

Through these changes, the CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to better Adapt changes in the Medicare Program.
- Promote competition, leading to more efficiency and accountability.
- Establish better coordination and communication between CMS, its Contractors and providers.
- Promote CMS' ability to negotiate incentives for Medicare contractors to perform well.

These changes will enhance the Agency's ability to more effectively manage claims processing for the Medicare program in the future and ensure that the future changes to the Medicare program's operating structure are free from unnecessary constraints.

Financial Management Reform

On a related topic, CMS currently lacks a dual entry financial management system that fully integrates the Agency's accounting systems with those of its Medicare contractors. Today, many Medicare contractors rely on PC-based spreadsheets and a series of fragmented and overlapping systems to maintain their accounts receivable. Most contractors do not use double entry accounting methods or have claims processing systems with general ledger capabilities. As a result, the accuracy of reported activities must be verified manually, which increases the risk of administrative and operational errors and misstatements. Despite these difficulties, I am proud that CMS has maintained clean audit opinions in recent years. A major component of the Department's Chief Financial Officer's (CFO) audit comprehensive plan is to replace these systems with a state-of-the-art, integrated accounting system, which will include our Medicare contractors' activities and ensure the Medicare Trust Funds and the Agency's financial operations are protected from needless waste and errors.

Conclusion

I want to assure you that Tom Scully and I are committed to working with this Committee and Congress on a bipartisan basis to strengthen the programs administered by the CMS. We already have taken the first steps towards improving CMS's management and changing the culture and attitude of the Agency. We are committed to strengthening beneficiary understanding of the Agency's programs, enhancing education and outreach to the Agency's provider and State partners, and reforming fee-for-service contracting so that the Agency's programs are prepared for the future. Thank you again for the opportunity to be here today. I appreciate your interest and commitment and I am happy to answer any questions.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)
STATE CONTACTS

Central Office Contact	State	Regional Office Contact
Bill Lasowski	**ALABAMA**	Jay Gavens
Richard Strauss	**ALASKA**	John Grabowski
Linda Murphy	**AMERICAN SAMOA**	Bruce Campbell
Rhonda Rhodes	**ARIZONA**	Ronald Reepen
Marty Svolos	**ARKANSAS**	Ford Blunt
Richard Chambers	**CALIFORNIA**	Pat Daley
Todd Lawson	**COLORADO**	Penny Finnegan
Susan Hill	**CONNECTICUT**	Elena Byrne
Mike Goldman	**DELAWARE**	Elizabeth Wheeler
Rick Fenton	**DISTRICT OF COLUMBIA**	Marguerite Clark
Penny Thompson	**FLORIDA**	Eugene Grasser
Linda Strumsky	**GEORGIA**	Hugh Webster
Janet Brunader	**GUAM**	Eddie Martin
Larry Reed	**HAWAII**	Susan Castlebury
Georgia Johnson	**IDAHO**	Judy Ramberg
Mary Beth Hance	**ILLINOIS**	Vera Drivalas
Anita Pinder	**INDIANA**	Jean Hall
Mary Jean Duckett	**IOWA**	Brenda Jackson
Frank Sokolik	**KANSAS**	Jackie Glaze
Sandy Haydock	**KENTUCKY**	Cathy Kasriel
Wayne Smith	**LOUISIANA**	Joe Reeder
Roger Buchanan	**MAINE**	Irv Rich
Randy Graydon	**MARYLAND**	James Hake
Tom Hamilton	**MASSACHUSETTS**	Patricia Hitz McKnight
Rachel Block	**MICHIGAN**	Ruth Hughes
Terry Pratt	**MINNESOTA**	Doris Ross
Pam Vocke	**MISSISSIPPI**	Vernell Britton
Steve Pelovitz	**MISSOURI**	Judith Flynn
Helene Fredeking	**MONTANA**	Robert Lyon
Dave Witt	**NEBRASKA**	Sharon Taggart
Judy Yost	**NEVADA**	Lee Netzer
Jan Tarantino	**NEW HAMPSHIRE**	Harold Finn
Fred Gladden	**NEW JERSEY**	Lou Schiro
Susan Cuerdon	**NEW MEXICO**	Jack Allen

Central Office Contact	State	Regional Office Contact
Charlene Brown	**NEW YORK**	Sue Kelly
Joe Razes	**NORTH CAROLINA**	Donna Cross
James Merrill	**NORTH DAKOTA**	Bernadette Quevedo-Mendoza
Irene Dustin	**N. MARIANA ISLANDS**	Mary Rydell
Deirdre Duzor	**OHIO**	Gwendolyn Sampson
Melissa Hulbert	**OKLAHOMA**	Phil Koether
Allissa DeBoy	**OREGON**	Dan Dolan
Cheryl Austein-Casnoff	**PENNSYLVANIA**	Michael Cruse
Cindy Melanson	**PUERTO RICO**	Frank Fournier
Rick Friedman	**RHODE ISLAND**	Richard Pecorella
Helaine Jeffers	**SOUTH CAROLINA**	Thomas Couch
David Eddinger	**SOUTH DAKOTA**	Cindy Myers
Mike Fiore	**TENNESSEE**	Patsy Evans
Dave McNally	**TEXAS**	Shirley Glaspie
Aaron Blight	**UTAH**	Tilly Rollin
Clarke Cagey	**VERMONT**	William Mackenzie
Ginni Hain	**VIRGINIA**	Jake Hubik
Cindy Graunke	**VIRGIN ISLANDS**	Ricardo Holligan
Gale Arden	**WASHINGTON**	Robert Reed
Joan Simmons	**WEST VIRGINIA**	Ted Gallagher
Glenn Stanton	**WISCONSIN**	Pam Carson
Marjorie Eddinger	**WYOMING**	Robert Tonsberg

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUL 30 2001

The Honorable Charles Grassley
United States Senate
Washington, DC 20510

Dear Senator Grassley:

Thank you for the opportunity for me to testify before the Senate Finance Committee regarding the future of Medicare. I look forward to continuing our constructive working relationship.

I am happy to report I have been busy implementing a number of administrative reforms at the Centers for Medicare & Medicaid Services (CMS). As you requested at the hearing, I am enclosing a list and brief description of the major administrative changes that have been implemented or will be implemented shortly.

In addition to the administrative reforms at CMS, you also asked for our legislative priorities. Medicare contracting reform is one of my top legislative priorities, and on June 28, 2001, we forwarded our proposal to Congress. I have enclosed a copy of the legislation. This proposal will allow us to manage the Medicare contractors more effectively and efficiently though performance based contracts.

Our proposal will:

- Provide flexibility to CMS and its contractors to work together more effectively and better adapt to changes in the Medicare program.
- Promote competition, leading to more efficiency and greater accountability.
- Establish better coordination and communication between CMS, contractors and providers.
- Promote CMS's ability to negotiate incentives to reward Medicare contractors that perform well.

Thank you for the opportunity to share my thoughts on these important issues. Your continued interest and support are essential for the Medicare program's success. If you have any questions or concerns, please do not hesitate to contact me. An identical letter is being sent to Mr. Baucus.

Sincerely,

Tommy G. Thompson

Enclosures

Centers for Medicare & Medicaid Services
Administrative Actions

Renamed Agency
On June 14, 2001, Administrator Scully and I announced that the Health Care Financing Administration would be renamed the Centers for Medicare & Medicaid Services (CMS). The change was made as part of a first wave of improvements to reform and strengthen the Agency's operations, and to improve access to information available to the nearly 70 million beneficiaries and the health care providers who serve them.

Agency Restructuring
As part of the Agency reorganization plan, CMS has been restructured into three Centers.

- ***The Center for Medicare Management*** (CMM) focuses on management of the traditional fee-for-service Medicare program, including development of payment policy and management of the Medicare fee-for-service contractors.

- ***The Center for Beneficiary Choices*** (CBC) focuses on the Medicare+Choice program and providing beneficiaries with information on Medicare, Medicare Select, Medicare+Choice and Medigap options. It also includes management of the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.

- ***The Center for Medicaid and State Operations*** (CMSO) focuses on programs administered by States, including Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA).

The Agency restructuring was effective July 1, 2001.

Culture of Responsiveness
Administrator Scully and I have made it a top priority to improve CMS's responsiveness to the concerns and interests of beneficiaries and the Agency's provider, plan, state and congressional partners. To help foster this new culture, the Agency is:

- ***Responding More Rapidly and Appropriately to Congress and External Partners*** by setting a new standard of promptly responding to congressional inquiries within fourteen days. The Agency also is exploring ways to make data, information, and trend analyses more readily available to the Agency's partners and the public in a timely manner.

- ***Consulting with Congressional Committees*** by establishing a regular schedule of meetings with three committees of jurisdiction – House Ways and Means, House Energy and Commerce and Senate Finance – to provide information on activities that the Agency is undertaking such as rulemaking and other program guidance.

- ***Enhancing Outreach and Education to Providers, Plans, and Practitioners*** by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. The Agency will provide improved training on new program requirements and payment system changes, increase the number of satellite broadcasts available to industry groups, and make greater use of web-based information and learning systems. The plan to enhance outreach and education is effective immediately.

- ***Establishing Key Contacts for the States*** at the regional and central office level. These staff will work directly with the Governors and State officials to help eliminate Agency obstacles in obtaining answers, feedback, and guidance on Medicaid and State Children's Health Insurance Program (SCHIP) matters. Each state will have one high-level Medicaid staff member assigned to them in their regional office and another in Baltimore, who will be accountable for their specific issues. This was effective June 19, 2001.

- ***Creating Primary Contacts*** for beneficiary groups, plans, physicians, providers, and suppliers to strengthen communication and information sharing between stakeholders and the Agency. Effective immediately, CMS will designate a senior-level staff member as the principal point-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The designees will help ensure that industry groups' voices are heard within CMS.

Regulatory Streamlining
CMS will work to eliminate regulatory red tape for the plans, providers and other stakeholders who provide services to Medicare beneficiaries. Far too many of our partners have raised concerns about the extent of the Medicare program's regulatory burden and the cost of doing business with Medicare. Administrator Scully and I are committed to taking swift action to reduce unnecessary burden and complexity. We need to streamline Medicare's requirements, bring openness and responsiveness into the process, and ensure that regulatory changes are sensible and predictable. CMS will:

- Move towards the use of electronic rulemaking as a means to reduce paper usage and make the rulemaking process more efficient. CMS already has started to post updated regulations on its website once they are published in the Federal Register. This innovation has been well received by providers and other interested parties.

- Issue a prototype quarterly compendium of all changes to Medicare instructions that affect providers. This will be effective October 2001.

Beneficiary Education Initiative
Later this year, CMS will launch an aggressive new education campaign to ensure that all Medicare beneficiaries understand the program, their coverage options, and the costs associated with the health care decisions they may make. CMS is:

- *Initiating a Multimedia Education Campaign* in fall 2001, to raise awareness among Medicare beneficiaries of their health care options. The Agency will use major television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers.

- *Increasing the Capacity of Medicare's Toll-Free Lines* so that the new wave of callers to 1-800-MEDICARE generated by the advertising campaign receives comprehensive information about the health plan options that are available in their specific area. By October 2001, the operating hours of the toll-free lines will be expanded and made available to beneficiaries, their families, and caregivers 24 hours a day, seven days a week. The information available by phone also will be significantly enhanced, so that specific information about the health plan choices available to beneficiaries in their state, county, city, or town can be obtained and questions about specific options, as well as costs associated with those options, can be answered.

- *Improving Internet Access to Comparative Information* and providing new decision-making support tools on our excellent beneficiary education website, www.medicare.gov, in the Fall 2001. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as *Nursing Home Compare* and *ESRD Compare* websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State-based comparative information on Medigap options and costs.

  For practicing physicians and their office staff, the existing array of Medicare information on the Agency website (www.hcfa.gov) is extensive, but is poorly presented for their office and billing needs. We are creating a new website architecture that takes this existing information and organizes navigation to be both easy and intuitive to the physician user. The same design is being used in creating a manual of "Medicare Basics" for physicians. We just completed field-testing the first mock-ups for the project at the recent American Medical Association House of Delegates meeting. Once this is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers.

  In addition, doctors, other providers, practice staff, and other interested individuals can use the website to access a growing number of informational courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits. From October 2000 to March 2001, the computer-based training courses have averaged over 14,000 hits per month.

Simplification of Patient Assessment Instruments
One of CMS's priorities is to undertake a thorough review of the assessment instruments that our programs employ. To determine what is truly required to adequately operate payment systems and perform quality improvements, we will evaluate the number of items included in the instruments and the frequency with which assessments must be completed. CMS will convene Technical Experts Panels to examine and simplify both the Outcome and Assessment Information Set (OASIS) and the Minimum Data Set (MDS).

Risk-Adjustment Mechanism for Medicare+Choice
It is my goal to preserve and expand the Medicare+Choice (M+C) program so that many other beneficiaries can benefit from this option. As a first step, I delayed the deadline for Medicare+Choice Organizations (M+COs) to submit notice of non-renewal for contract year 2002 until September 17, 2001. M+COs will be required to submit, by July 2, 2001, summary, non-binding information required for their rate and benefit filings. However, this information will not be made public and the complete, final band binding filing will not be due until September 17, 2001.

I believe these steps will allow M+COs additional time to collect cost data and to determine the viability of their provider networks prior to making a decision for 2002 with respect to their benefits and service areas. It will also allow time for benefit approval and beneficiary notification. I will continue working with the Congress to determine if it is possible, on a permanent basis, to modify the legislative date for submission of rate and benefit filings.

In addition, after reviewing the Department's proposed implementation of its risk-adjustment mechanism, I suspended the required filing of physician and hospital outpatient encounter data through July 1, 2002. In the interim, the Department will work closely with all interested parties to explore and implement a risk adjustment process for M+C payments that balances accuracy and administrative burden. We are committed to the implementation of an improved risk adjustment methodology. CMS will explore the use of alternative data collection methods that will be less burdensome to the managed care industry. In the event that a satisfactory alternative is not available, CMS will resume collection of physician and hospital outpatient encounter data in July 2002.

Expansion of Single Task Workers
While in Wisconsin, we successfully utilized "single task workers" in situations that are safe and appropriate. At a recent hearing before the Senate Special Committee on Aging, I announced that the Centers for Medicare & Medicaid Services will provide administrative guidance to the States that will enable greater use of single task workers in transporting nursing home residents from one area of the facility to another. CMS will also issue a proposed regulation to address other types of single tasks as well.

Medicaid and the State Children's Health Insurance Program
- On June 22, 2001, we issued a regulation aimed at providing health coverage to more children in the United States. The rule gives states increased flexibility under SCHIP to provide coverage and enables States to use streamlined enrollment procedures. With this

new flexibility for States, we hope millions more children will gain access to needed health care services.

- In the past four months, I have approved more than 600 Medicaid and SCHIP waivers and State Plan Amendments. I have authorized these changes because people with immediate needs cannot wait for a rumbling bureaucracy to plod along. Since I became Secretary, we have reengineered the Medicaid waiver process with a focus on "getting to 'yes'." We are working with States to be more responsive and timely in our decision-making on waivers and amendments, to encourage innovation by the States and to grand speedy approval for "look-alike" waivers. We are also cleaning-up the backlog of State Plan Amendments, now have a new database in place to track the status of State waiver requests and are fostering a new culture at CMS of giving States an answer in a timely manner.

- In March 2001, we published a proposed regulation that would create a new, shorter transition period for the new Medicaid upper payment limit requirements for those states that had pending plan amendments as of March 13, 2001 – the effective date of the January 12, 2001, final rule designed to close the loophole. Although those plans will be considered under the rules in effect at the time they were submitted, the new proposed rule would shorten the transition period for those plans to a single year. The rule estimates $600 million in potential savings from the change compared to the cost of what would happen if the affected plans had received a full two-year transition.

Summary of Pending CMS Regulations

As previously noted, beginning October 1, we will publish a quarterly compendium of all CMS regulations and instructions impacting providers. The compendium will contain a listing of the regulations CMS expects to publish in the *Federal Register* within the next 90 days, as well as provide the day each month that the public can look for CMS documents in the *Federal Register*. As a courtesy, the compendium will also contain a listing of the regulations that were published in the past 90 days as well as on what dates they were published. The compendium will subsequently be published on a quarterly basis on the first business day of each calendar year quarter.

Attached, you will find a listing of the congressionally mandated regulations that are currently under development within CMS. In several instances the same provision is listed twice in recognition that we must publish both a proposed rule and a final rule. It is expected that as these regulations move forward they will be included in the quarterly compendium.

Future Changes to CMS's Data Systems

CMS's Information Technology (IT) environment is large and complex, and supports our four main business areas: Program Operations (ie, Medicare fee-for-service claims processing, Managed Care, Medicaid, and CLIA), Program Development (ie, data management – supporting policy development, actuarial science, education, research, etc.), Infrastructure Support (ie, CMS data center, internal networks, intranet, extranet, and e-mail), and Security and Privacy. Our IT vision involves building an IT architecture that better supports our existing business operations and allows us to more effectively respond to our changing business needs. Our goal is to stabilize our current systems environment, modernize our systems, and manage our IT

investments wisely. Our target architecture, which is depicted in the attached "Sunflower" diagram, will eliminate replicated functions, provide a reliable, single data source, and safeguard the confidentiality, integrity, and availability of data through unified security practices.

We are building incrementally and modularly towards our envisioned architecture, while maintaining our current operations. We are taking several key steps toward reaching our goals. We are:

- ***Consolidating our claims processing systems into three selected systems.***
  In 1998, we transitioned all durable medical equipment claims processing carriers into a single system. We have transitioned twenty-three intermediaries to the selected Part A system. We have suspended further Part A transitions while we compete the contract for the selected system and to ensure stability. We expect to resume the Part A transitions in 2003. We are also in the process of transitioning Part B carriers to the Part B selected system. Over 60 percent of Part B claims are now processed on the selected system, and we are continuing to transition the carriers that use the three remaining systems on a system-by-system basis. We expect to complete the transition in 2004.

- ***Implementing a dual-entry accounting system (HIGLAS).***
  One of CMS's greatest financial management challenges is the lack of a dual entry financial management system that fully integrates CMS's accounting systems with those of our Medicare contractors. One of our top priorities is to purchase a state-of-the-art, integrated accounting system, or HIGLAS, which will include our Medicare contractors' activities. HIGLAS represents a major information technology investment to standardize the collection, recording, and reporting of Medicare financial information in order to enhance the management, accounting, and oversight of our programs. The project is well underway. On January 31, 2001, we issued a request for quotation and demonstration that will result in the procurement and implementation of a commercial-off-the-shelf accounting system. We will select a vendor for HIGLAS by October 2001. Our implementation plan includes pilots at two Medicare contractors, a fiscal intermediary and a carrier, in October 2002, and our goal is to have HIGLAS fully implemented at all Medicare contractors by fall 2006. We will begin work on the central office's core accounting and administrative functions after completion of the pilot projects. We expect to begin full operation under HIGLAS in 2007.

- ***Redesigning the Medicare Managed Care System.***
  We have initiated a Medicare Managed Care System Redesign program which will allow us to switch from an outdated database environment to a more current, industry-supported one. The redesign program consists of five, integrated software development efforts, including:
  - Implementation of a new Medicare beneficiary database into the current managed care systems environment in June 2001.
  - Implementation of a new beneficiary enrollment and capitation system in May 2003.
  - Implementation of the risk adjustment system, to develop beneficiary risk adjustment factors for computing beneficiary capitation amounts in July 2003.
  - Implementation of the Medicare Managed Care Beneficiary Appeals system, to record and report on beneficiary appeals of M+C plan service denials in August 2003.

- Implementation of the Medicare Managed Care Plan Payment System to compute and track monthly plan payments on behalf of Medicare enrollees in September 2003.

- *Modernizing our Enrollment and Utilization Databases.*
  - *Medicare Beneficiary Database* – We are in the process of modernizing the Medicare Beneficiary Database, which provides a complete insurance profile, including beneficiaries' health insurance choices and coverage both inside and outside of the Medicare program, as well as liability status information. The database will give us a central repository of beneficiary level data for the first time. Once populated and integrated with other systems, the new database will be the authoritative source of beneficiary level information and will provide full support for a wide array of benefit plans and choices, including managed care enrollments, payments to Managed Care Organizations, and other Agency functions. Data from the Enrollment Database and the Group Health Plan systems were recently loaded into the Medicare Beneficiary Database, and should be available for the Central Office, Regional Offices and Managed Care Organizations in query mode in August 2001.

  - *National Medicare Utilization Database* – We also are modernizing the National Medicare Utilization Database, which is the repository of all Medicare claims data. This custom-developed database contains the beneficiary-specific claims history data, which will allow us to build future operational data marts. This is something that is not possible under our current system in which data is stored on hundreds of tape cartridges. The new database will allow a higher degree of analysis and accessibility of Medicare claims data than is currently possible. We will load and test the database in 2002, and we expect that it will be fully operational in 2003.

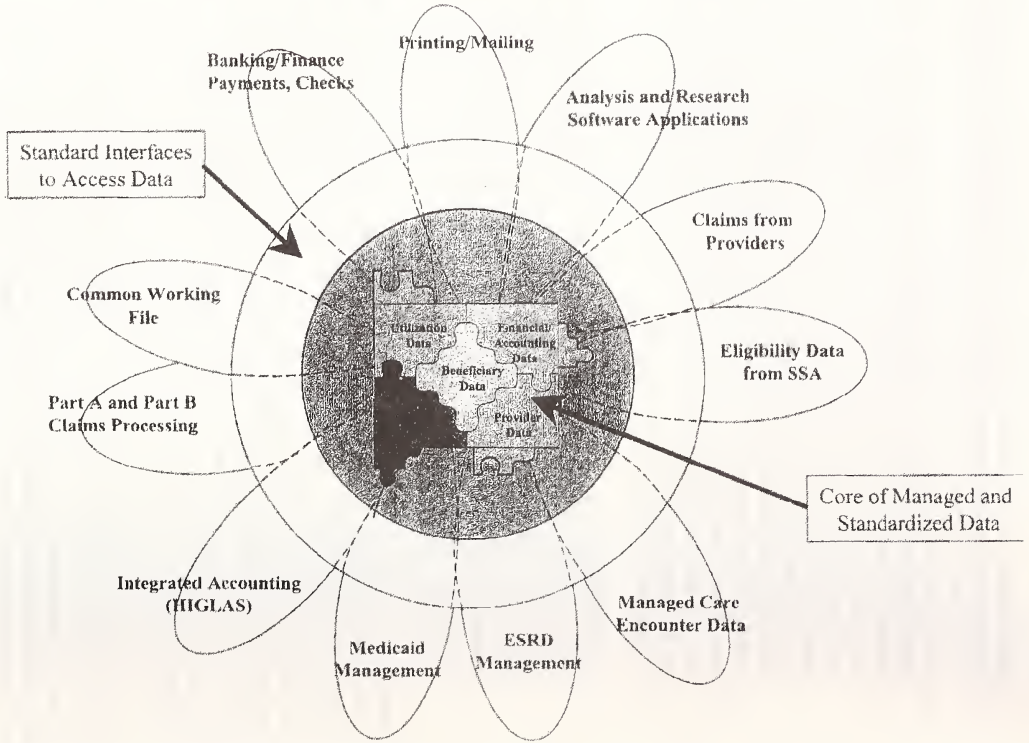
Medicare Rx Discount Card Program

President Bush has announced a new Medicare-endorsed prescription drug discount card program, which will immediately help beneficiaries receive discounts on drugs. All Medicare beneficiaries will be able to enroll in their choice of several Medicare-endorsed discount card organizations. Each discount card organization will conduct its own enrollment activities, enrolling individuals or groups of individuals (including M+C plan members, Medigap enrollees and beneficiaries with employer-sponsored retiree health insurance), and 1-800-MEDICARE as well as www.medicare.gov will provide general information and refer beneficiaries to individual programs. Enrollment in the Medicare Rx Discount Card Program will begin as early as November 1, 2001.

CMS will annually endorse private organizations that meet certain qualifications, including financial stability, accessibility, availability of discounts, ability to communicate discounts to enrollees and other customer service features. Each program can use formularies, patient education, pharmacy networks, mail order and other commonly used tools to secure deeper discounts for beneficiaries. The endorsed programs will be expected to fund the cost of administering their programs through manufacturer rebates, administrative fees or other means.

Each of the endorsed discount card programs will participate in and fund a private consortium that will conduct several administrative functions, including development and implementation of a system to ensure that beneficiaries are enrolled in only one program at a time; making comparative discount and other information available; and reviewing marketing materials used by the discount card programs. Member organizations will make decisions about ongoing operations of the consortium.

The HCFA IT Vision



Status of Congressionally Mandated Regulations

HCFA CODE	*TITLE*	*RIN*	*STATUS*
CMS-0003-P	Health Insurance Reform: Modifications to Standards for Electronic Transaction	0938-AK64	Under development
CMS-0005-P	Revisions to Transaction and Code Set Standards for Electronic Transactions	0938-AK76	Under development
CMS-0006-F	Standards for Electronic Transactions-Elimination of NDC Coding Standards	0938-AK86	Under development
CMS-0006-P	Standards for Electronic Transactions-Elimination of NDC Coding Standards	0938-AK86	Under development
CMS-0045-F	Standard Unique Health Care Provider Identifier	0938-AH99	Under development
CMS-0047-F	Unique Identifier for Employers	0938-AI59	Under development
CMS-0049-F	Security Standards (HIPPA)	0938-AI57	Under development
CMS-0050-F	Claims Attachment Standard (HIPAA Section 262)	0938-AK62	Under development
CMS-0050-P	Claims Attachment Standard (HIPAA Section 262)	0938-AK62	Under development
CMS-0051-F	Standards for Electronic Signatures	0938-AK63	Under development
CMS-0149-F2	Standards for Electronic Transactions	0938-AI58	Under development
CMS-1002-FC	Fee Schedule for Payment of Ambulance Services	0938-AK30	Under development
CMS-1010-F	Replacement of Reasonable Charge Methodology by Fee Schedule	0938-AK66	Under development
CMS-1022-F	Medicare Hospice Care Amendments	0938-AJ36	Under development
CMS-1022-P	Medicare Hospice Care Amendments	0938-AJ36	Under development

HCFA CODE	*TITLE*	*RIN*	*STATUS*
CMS-1063-F	Emergency Medical Treatment and Labor Act (EMTALA)	0938-AJ39	Under development
CMS-1063-P	Emergency Medical Treatment and Labor Act (EMTALA)	0938-AJ39	Under development
CMS-1069-FC	Medicare Program: Prospective Payment System for Inpatient Rehabilitation Hospital Services	0938-AJ55	Under development
CMS-1089-F	Payment for Clinical Psychology Training Programs	0938-AK15	Under development
CMS-1158-F	Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2002 Rates	0938-AK73	Under development
CMS-1159-F	Hospital Outpatient Prospective Payment System (OP PPS) for CY 2002	0938-AK54	Under development
CMS-1159-P	Hospital Outpatient Prospective Payment System (OP PPS) for CY 2002	0938-AK54	Under development
CMS-1161-NC	Home Health Prospective Payment System Rate Update for FY 2003	0938-AK93	Under development
CMS-1163-F	Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2002	0938-AK47	Under development
CMS-1169-F	Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002	0938-AK57	Under development
CMS-1169-P	Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002	0938-AK57	Under development
CMS-1171-F	Medicare Inpatient Disproportionate Share Hospital Adjustment Calculation	0938-AK77	Under development
CMS-1171-P	Medicare Inpatient Disproportionate Share Hospital Adjustment Calculation	0938-AK77	Under development

HCFA CODE	TITLE	RIN	STATUS
CMS-1175-N	Medicare Program: Hospice Wage Index FY 2002	0938-ZA08	Under development
CMS-1177-P	Long Term Care Prospective Payment System for Fiscal Year 2003	0938-AK69	Under development
CMS-1179-IFC	Revisions to the Prospective Payment System for Hospital Outpatient Services Mandated by BIPA	0938-AK59	Under development
CMS-1180-F	Modifications to Managed Care Rules Based on Provisions of BIPA and Technical Corrections	0938-AK71	Under development
CMS-1180-P	Modifications to Managed Care Rules Based on Provisions of BIPA	0938-AK71	Under development
CMS-1181-F	Modifications to Managed Care Rules Based on Provisions in BIPA, and Technical Corrections	0938-AK90	Under development
CMS-1182-FN	Medicare+Choice ESRD Rates	0938-AK75	Under development
CMS-1810-FC	Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships-Phase II	0938-AK67	Under development
CMS-1885-FC	Update of Ratesetting Methodology, Payment Rates and the List of Covered Surgical Procedure for Ambulatory Surgical Centers	0938-AH81	Under development
CMS-1908-F	Application of Inherent Reasonableness to All Part B Services Other Than Physician Services	0938-AJ97	Under development
CMS-2001-F	Medicaid Managed Care; Regulatory Program to Implement Certain Medicaid Provisions of the Balanced Budget Act of 1997	0938-AI70	Delayed until 08/17/2001
CMS-2015-F	External Quality Review of Medicaid Managed Care Organizations	0938-AJ06	Under development
CMS-2022-F	HIPPA; Nondiscrimination in Health Coverage in the Group Market	0938-AI08	Under development

HCFA CODE	TITLE	RIN	STATUS
CMS-2033-IFC	Non-Federal Governmental Plans Exempt from HIPAA	0938-AK00	Under development
CMS-2040-IFC	Protection for Women Who Elect Reconstruction After a Mastectomy	0938-AJ44	Under development
CMS-2046-F	Medicaid Payment for Covered Outpatient Drugs Under Rebate Agreements	0938-AF42	Under development
CMS-2047-FC	Requirements for Enrollment of Medicaid Recipients Under Cost Effective Employer-Based Group Health Plans	0938-AH48	Under development
CMS-2048-F	Portability in the Group Health Insurance Market	0938-AK88	Under development
CMS-2062-N	Disproportionate Share Hospital (DSH) Payments--Institutions for Mental Disease (IMDs)	0938-AJ74	Under development
CMS-2070-N	Mandatory Transmission of Outcome and Assessment Information Set (OASIS) for Non-Medicare/Non-Medicaid Patients in Home Health Agencies and Continued Delay of Requirements for Patients Receiving Personal Care Services	0938-ZA11	Under development
CMS-2078-F	HIPAA; Notice of Proposed Rulemaking for Bona Fide Wellness Programs	0938-AK19	Under development
CMS-2080-F	Liability for Third Parties to Pay for Services	0938-AH01	Under development
CMS-2080-P	Liability for Third Parties to Pay for Services	0938-AH01	Under development
CMS-2081-F	Medicaid: Medical Child Support	0938-AI21	Under development
CMS-2081-P	Medicaid: Medical Child Support	0938-AI21	Under development
CMS-2088-P	Hospital Oversight Initiative (HOI) Work and Regulatory Conformity with Statutory Requirements	0938-AK36	Under development
CMS-2094-F	Requirements for Directors of Laboratories Performing High Complexity Testing	0938-AK83	Under development

HCFA CODE	*TITLE*	*RIN*	*STATUS*
CMS-2094-P	Requirements for Directors of Laboratories Performing High Complexity Testing	0938-AK83	Under development
CMS-2226-F	Clinical Lab Requirements-Revisions to Regulations Implementing CLIA	0938-AK24	Under development
CMS-2882-F	Portability in the Individual Health Insurance Market; Process for States	0938-AH75	Under development
CMS-3055-F	Increase in the Rate of Reimbursement of Photocopy Expenses for Prospective Payment System Providers	0938-AK68	Under development
CMS-3055-P	Increase in the Rate of Reimbursement of Photocopy Expenses for Prospective Payment System Providers	0938-AK68	Under development
CMS-3062-N	Revised Process for Making Medicare National Coverage Determinations (NCDs)	0938-AK61	Under development
CMS-3063-P	Reviews of National Coverage Determinations and Local Coverage Determinations	0938-AK60	Under development
CMS-3250-F	Clinical Diagnostic Lab Test: Negotiated Rulemaking	0938-AI92	Under development
CMS-3745-F	Revision of Medicare/Medicaid Hospital Conditions of Participation	0938-AG79	Under development
CMS-4007-P	Supplementary Medical Insurance Premium Surcharge Agreements	0938-AK42	Under development
CMS-6001-P	Surety Bond Requirements for Home Health Agencies	0938-AJ81	Under development
CMS-6002-P	Requirements for Establishing and Maintaining Medicare Billing Privileges	0938-AH73	Under development
CMS-6010-F	Supplier Standards Related to Training Requirements for Oxygen, Therapeutic Shoes	0938-AJ98	Under development
CMS-6010-P	Supplier Standards Related to Training Requirements for Oxygen, Therapeutic Shoes	0938-AJ98	Under development

HCFA CODE	*TITLE*	*RIN*	*STATUS*
CMS-6145-FC	Civil Money Penalties, Assessments, and Revised Sanction Authorities	0938-AK49	Under development
CMS-8011-N	Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2002		Under development
CMS-8012-N	Part A Premium for 2002 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement		Under development
HCFA-1147-NC	Update to the Home Health Prospective Payment System for FY 2002	0938-AK51	Published 06/29/2001
HCFA-1158-P	Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2002 Rates	0938-AK73	Published on 05/04/2001
HCFA-1158-P	Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2002 Rates	0938-AK73	Published on 05/04/2001
HCFA-1163-P	Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2002	0938-AK47	Published on 05/10/2001
HCFA-1182-PN	Medicare+Choice ESRD Rates	0938-AK75	Published on 05/01/2001
HCFA-1186-N	Procedures for Public Consultations for Coding and Payment Determinations for New Laboratory Tests	0938-AK80	Published on 06/29/2001
HCFA-1685-F	Medicare Program; Payment for Nursing and Allied Health Education	0938-AE79	Published on 01/12/2001; Effective on 05/14/2001
HCFA-1809-FC	Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships	0938-AG80	Published on 1/4/2001
HCFA-2006-F	The Children's Health Insurance Program: Implementing the Balanced Budget Act of 1997	0938-AJ75	Published on 01/11/2001

"Medicare Contracting Reform Amendments of 2001"

Section-by-Section Summary

(Except as otherwise indicated, this bill amends provisions of the Social Security Act. References to the "Secretary" are to the Secretary of Health and Human Services.)

SEC. 2. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

Section 2 proposes reforms to provide for increased flexibility in contracts with Medicare fiscal intermediaries (entities that process claims under part A of the Medicare program) and carriers (entities that process claims under part B of the Medicare program), including contracts with entities that perform both intermediary and carrier functions. Except where otherwise noted, these amendments permit the Secretary to contract competitively for administration of benefits under parts A and B in accordance with standard government contracting procedures set forth in the Federal Acquisition Regulation.

SECRETARIAL FLEXIBILITY IN CONTRACTING FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CARRIER FUNCTIONS

Subsection (a) includes a number of amendments designed to provide greater flexibility and accountability in contracting for administration of benefits under parts A and B of the Medicare program. This subsection amends section 1816(a) to replace the current system of nominating fiscal intermediaries with one under which the Secretary could contract with an appropriate number of agencies or organizations to perform functions such as (1) determining payment amounts due to providers of services and making such payments, (2) providing consultative services to enable entities to establish fiscal records and otherwise to qualify as providers of services; (3) serving as a communication point for Medicare beneficiaries and providers of services; and (4) performing audit functions with respect to provider records. While this legislation may result in a reduced number of contractors, it will maintain the appropriate number of contractors needed to address local concerns, such as timely coverage of local treatment innovations, in accordance with applicable Medicare provisions.

Subsection (a) also amends sections 1816 and 1842 to ensure that each provider of services has a fiscal intermediary that will act as a single point of contact for the provider; makes its services sufficiently available to meet the provider's needs; and helps resolve any issues raised by the provider under part A. In addition, subsection (a) amends sections 1816 and 1842 to explicitly authorize the Secretary to contract with fiscal intermediaries or carriers for the performance of one or more functions, or parts of any function.

ANY QUALIFIED ENTITY ELIGIBLE TO SERVE AS A FISCAL INTERMEDIARY OR CARRIER

Subsection (b) amends sections 1816 and 1842 to provide that the Secretary may contract with any agency or organization for performance of fiscal intermediary or carrier services, and it strikes section 1842(f), which limits the Secretary's ability to contract for carrier services with entities that are not health insurers.

SECRETARY'S AUTHORITY TO ENTER INTO SINGLE OR SEPARATE CONTRACTS FOR ADMINISTRATION OF BENEFITS UNDER PARTS A AND B

Subsection (c) amends section 1842(a) to clarify the Secretary's authority to execute combined contracts for fiscal intermediary and carrier services.

SECRETARY'S EVALUATION OF THE PERFORMANCE OF FISCAL INTERMEDIARIES AND CARRIERS

Subsection (d) amends sections 1816 and 1842 to (1) eliminate provisions that require the Secretary to evaluate fiscal intermediary and carrier performance using standards and criteria promulgated through the Federal Register; and (2) establish an evaluation system that is consistent with standard Federal government contracting procedures. Under the proposed system, the Secretary's evaluation of fiscal intermediary and carrier performance would be based on contract performance requirements, such as fiscal integrity, timeliness of claims processing, and contractor responsiveness to provider and beneficiary concerns. Subsection (d) specifies that these performance requirements must also include certain time frames for reconsidering claims.

REPEAL OF COST REIMBURSEMENT REQUIREMENTS

Subsection (e) amends sections 1816 and 1842 to repeal the requirement that fiscal intermediaries and carriers be paid on a cost reimbursement basis. This amendment would permit the Secretary to contract for fiscal intermediary and carrier services on any basis permitted by the Federal Acquisition Regulation.

CLARIFICATION OF FISCAL INTERMEDIARY AND CARRIER LIABILITY.

Subsection (f) amends sections 1816 and 1842 to clarify that fiscal intermediaries and carriers are liable to the United States if, in making Medicare payments, their certifying or disbursing officers acted with gross negligence, recklessness, or knowledge, or with intent

to defraud the United States. This amendment addresses a statutory ambiguity under which a federal court held Medicare contractors were immune from liability regardless of misconduct by their certifying or disbursing officers (*United States ex rel. Body v. Blue Cross and Blue Shield of Alabama (11th Cir. 1998)*. This clarification is narrow in scope and is not intended to otherwise affect interpretation or enforcement of the False Claims Act or any related civil or criminal statute.

Subsection (f) also codifies provisions of fiscal intermediary and carrier contracts under which (1) the civil liability of Medicare contractors to third parties is explicitly limited; and (2) the Secretary will indemnify Medicare contractors for the reasonable expenses of defending against third party civil suits. This subsection makes both the liability limitation and indemnification provisions contingent on the contractors' exercise of due care in performing their contractual functions and duties.

ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS

Subsection (g) strikes sections 1816(g) and 1842(b)(5) to eliminate special requirements for terminating contracts with fiscal intermediaries and carriers that are not consistent with the provisions of the Federal Acquisition Regulation.

SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS

Subsection (h) amends sections 1816 and 1842(b) to (1) provide that initial contracts with fiscal intermediaries and carriers are subject to the competitive requirements that apply throughout the Federal government; and (2) authorize the Secretary to renew contracts, and to transfer functions among fiscal intermediaries and carriers, without competition if the fiscal intermediaries and carriers have met or exceeded contract performance requirements.

WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS

Subsection (i) permits the Secretary to enter into the first round of fiscal intermediary and carrier contracts under the new provisions without competition.

AMENDMENTS TO CONFORM CONTRACTING TERMINOLOGY TO THAT USED IN THE FEDERAL ACQUISITION REGULATION

Subsection (j) amends sections 1816 and 1842 to replace current references to "agreements" with fiscal intermediaries and carriers with references to "contracts" with such entities in order to make the references consistent with terminology used in the Federal Acquisition Regulation.

EFFECTIVE DATES

Subsection (k) provides the effective dates for the amendments made by the section.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 28 2001

The Honorable Richard B. Cheney
President, United States Senate
Washington, D.C. 20510

Dear Mr. President:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicare Contracting Reform Amendments of 2001". Key features of the bill are outlined below. The provisions of the bill are described in greater detail in the enclosed section-by-section summary.

The bill would make amendments to the Medicare statute under title XVIII of the Social Security Act to increase the Secretary's flexibility in contracting with fiscal intermediaries and carriers for administration of benefits under parts A and B of the Medicare program. Notably, the bill would (1) allow the Secretary increased flexibility in contracting for claims processing and payment functions on behalf of Medicare beneficiaries and providers; (2) allow the Secretary to contract for Medicare functions on any basis permitted by the Federal Acquisition Regulation; (3) eliminate special provisions under current law for terminating contracts with fiscal intermediaries and carriers; and (4) explicitly authorize the Secretary to execute combined contracts for administration of benefits under Medicare parts A and B.

By allowing the Secretary this increased flexibility, the bill would improve the cost effectiveness of Medicare contractor operations and create an open marketplace for potential contracting partners. At the same time, the bill is not intended to affect the current relationship between local physicians and other providers and Medicare fee-for-service contractors. We will continue to obtain input from the provider community for activities such as the development of local medical review policies and provider education and training.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,

Tommy G. Thompson

Enclosures

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 28 2001

The Honorable J. Dennis Hastert
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicare Contracting Reform Amendments of 2001". Key features of the bill are outlined below. The provisions of the bill are described in greater detail in the enclosed section-by-section summary.

The bill would make amendments to the Medicare statute under title XVIII of the Social Security Act to increase the Secretary's flexibility in contracting with fiscal intermediaries and carriers for administration of benefits under parts A and B of the Medicare program. Notably, the bill would (1) allow the Secretary increased flexibility in contracting for claims processing and payment functions on behalf of Medicare beneficiaries and providers; (2) allow the Secretary to contract for Medicare functions on any basis permitted by the Federal Acquisition Regulation; (3) eliminate special provisions under current law for terminating contracts with fiscal intermediaries and carriers; and (4) explicitly authorize the Secretary to execute combined contracts for administration of benefits under Medicare parts A and B.

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Sincerely,

Tommy G. Thompson

Enclosures

A BILL

To amend title XVIII of the Social Security Act to increase flexibility in Medicare claims processing, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Contracting Reform Amendments of 2001".

(b) REFERENCES IN ACT.—Except as otherwise specified, amendments made by this Act to a section or other provision of law are amendments to such section or other provision of the Social Security Act.

SEC. 2. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) SECRETARIAL FLEXIBILITY IN CONTRACTING FOR FISCAL INTERMEDIARY AND CARRIER FUNCTIONS.—

(1) FISCAL INTERMEDIARY FUNCTIONS.—

(A) IN GENERAL.—Section 1816 (42 U.S.C. 1395h) is amended by striking the heading and the remaining text preceding subsection (b) and inserting the following:

"USE OF FISCAL INTERMEDIARIES FOR ADMINISTRATION OF BENEFITS

"SEC. 1816. (a)(1) The Secretary may enter into contracts with agencies or organizations (referred to as fiscal intermediaries) to perform any or all of the following functions, or parts of

those functions (or, to the extent provided in a contract, to secure performance thereof by other organizations):

"(A) determine (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this part to be made to providers of services,

"(B) make payments described in subparagraph (A),

"(C) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services,

"(D) serve as a center for, and communicate to individuals entitled to benefits under this part and to providers of services, any information or instructions furnished to the agency or organization by the Secretary, and serve as a channel of communication from individuals entitled to benefits under this part and from providers of services to the Secretary,

"(E) make such audits of the records of providers of services as may be necessary to insure that proper payments are made under this part,

"(F) perform the functions described in subsection (d), and

"(G) perform such other functions as are necessary to carry out the purposes of this part.".

(B) FUNCTIONS TO BE PERFORMED ON BEHALF OF PROVIDERS.— Section 1816(d) (42 U.S.C. 1395h(d)) is amended to read as follows:

"(d) Each provider of services shall have a fiscal intermediary that—

"(1) acts as a single point of contact for the provider of services under this part,

"(2) makes its services sufficiently available to meet the needs of the provider of services, and

"(3) is responsible and accountable for arranging the resolution of issues raised under this part by the provider of services.".

(C) CONFORMING AMENDMENTS.—Section 1816 (42 U.S.C. 1395h) is amended—

(i) in subsection (c)—

(I) in paragraph (2)(A), by inserting "that provides for making payments under this part" after "this section"; and

(II) in paragraph (3)(A), by inserting "that provides for making payments under this part" after "this section"; and

(ii) in subsection (k), by inserting "(as appropriate)" after "submit".

(2) CARRIER FUNCTIONS.—

(A) SECRETARY'S AUTHORITY TO CONTRACT WITH CARRIERS TO PERFORM ONE OR MORE FUNCTIONS, OR PARTS OF FUNCTIONS.—

(i) IN GENERAL.—Section 1842(a) (42 U.S.C. 1395u(a)) is amended in the matter preceding paragraph (1) by striking "some or all of the following functions" and inserting "any or all of the following functions, or parts of those functions".

(ii) CONFORMING AMENDMENTS.—Section 1842 (42 U.S.C. 1395u)) is amended—

(I) in subsection (b)—

(aa) in paragraph (2)(C), by inserting "(as appropriate)" after "carriers";

(bb) in paragraph (3), in the matter preceding subparagraph (A), by inserting "(as appropriate)" after "carriers";

(cc) in paragraph (7)(A), in the matter preceding clause (i), by striking "the carrier" and inserting "a carrier"; and

(dd) in paragraph (11)(A), in the matter preceding clause (i), by inserting "(as appropriate)" after "each carrier"; and

(II) in subsection (h)—

(aa) in paragraph (2), in the first sentence, by inserting "(as appropriate)" after "shall"; and

(bb) in paragraph (5)(A), by inserting "(as appropriate)" after "carriers".

(B) CLARIFICATION CONCERNING CARRIER COMMUNICATION RESPONSIBILITIES.—Section 1842(a)(3) (42 U.S.C. 1395u(a)(3)) is amended by inserting "(to and from individuals enrolled under this part and to and from

physicians and other entities that furnish items and services)" after "communication".

(b) ANY QUALIFIED ENTITY ELIGIBLE TO SERVE AS A FISCAL INTERMEDIARY OR CARRIER.—

(1) ELIGIBILITY TO SERVE AS A FISCAL INTERMEDIARY.—Section 1816(a) (42 U.S.C. 1395h(a)), as amended by subsection (a)(1)(A), is further amended by adding at the end the following new paragraph:

"(2) As used in this title and title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.".

(2) ELIGIBILITY TO SERVE AS A CARRIER.—Section 1842 (42 U.S.C. 1395u) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking "with carriers" and inserting "with agencies and organizations (referred to as carriers)"; and

(B) by striking subsection (f).

(c) SECRETARY'S AUTHORITY TO ENTER INTO SINGLE OR SEPARATE CONTRACTS FOR ADMINISTRATION OF BENEFITS UNDER PARTS A AND B.—Section 1842(a) (42 U.S.C. 1395u(a)) is amended in the matter preceding paragraph (1) by striking "carriers with which agreements" and inserting "single contracts under section 1816 and this section together, or separate contracts with agencies and organizations with which contracts".

(d) SECRETARY'S EVALUATION OF THE PERFORMANCE OF FISCAL INTERMEDIARIES AND CARRIERS.—

(1) EVALUATION OF FISCAL INTERMEDIARY PERFORMANCE.—Section 1816 (42 U.S.C. 1395h) is amended—

(A) in subsection (b)(1)(A), by striking "after applying the standards, criteria, and procedures" and inserting "after evaluating the ability of the agency or organization to fulfill the contract performance requirements";

(B) by striking subsection (e); and

(C) by amending subsection (f) to read as follows:

"(f) To the extent not inconsistent with section 1869, the contract performance requirements shall include, with respect to claims for services furnished under this part by any provider of services other than a hospital, that such agency or organization process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days.".

(2) EVALUATION OF CARRIER PERFORMANCE.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended—

(A) in subparagraph (A), by striking the second and third sentences;

(B) in subparagraph (B), in the matter preceding clause (i), by striking "establish standards" and inserting "develop contract performance requirements"; and

(C) in subparagraph (D)—

(i) by striking "standards and criteria" each place it occurs and inserting "contract performance requirements"; and

(ii) by striking "for evaluating carrier performance" after "by the Secretary".

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) PAYMENT OF FISCAL INTERMEDIARIES.—Section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) in the first sentence—

(i) by striking the comma after "appropriate" and inserting "and"; and

(ii) by striking ", and shall provide for payment" and the remaining text preceding the period; and

(B) by striking the second and third sentences.

(2) PAYMENT OF CARRIERS.—Section 1842(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) in the first sentence—

(i) by striking "shall provide" the first place it occurs and inserting "may provide"; and

(ii) by striking ", and shall provide for payment" and the remaining text preceding the period; and

(B) by striking the remaining sentences.

(3) REPEAL OF LIMITED AUTHORITY TO CONTRACT ON OTHER THAN COST REIMBURSEMENT BASIS.—Section 2326(a) of the Deficit Reduction Act of 1984 (42 U.S.C. 1395h nt) is repealed.

(f) CLARIFICATION OF FISCAL INTERMEDIARY AND CARRIER LIABILITY.—

(1) LIABILITY OF FISCAL INTERMEDIARIES FOR FUNCTIONS

PERFORMED UNDER SECTION 1816.—

(A) LIABILITY TO THE UNITED STATES.— Section 1816(i) (42 U.S.C. 1395h(i)) is amended—

(i) in paragraph (1) by inserting ", recklessness, or knowledge," after "gross negligence";

(ii) in paragraph (2) by inserting ", recklessness, or knowledge," after "gross negligence";

(iii) in paragraph (3) by striking all that follows "(3)" and inserting "An agency or organization shall be liable to the United States for a payment referred to in paragraph (1) or (2) if, in connection with such payment, an individual referred to in such paragraph acted with gross negligence, recklessness, or knowledge, or with intent to defraud the United States."; and

(iv) in paragraph (2) by striking "a voucher signed by" and inserting "an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of" after "based upon".

(B) LIABILITY TO THIRD PARTIES.— Section 1816 (42 U.S.C. 1395h) is amended by inserting at the end the following:

"(m) LIMITATION ON CIVIL LIABILITY.—

"(1) IN GENERAL.—No agency or organization having a contract with the Secretary under this section, and no person employed by, or having a fiduciary

relationship with, any such agency or organization or who furnishes professional services to such agency or organization, shall by reason of the performance of any duty, function or activity required or authorized pursuant to this section or to a valid contract entered into under this section, be held to be civilly liable under any law of the United States or of any State (or political subdivision thereof), unless such agency or organization or person failed to exercise due care in the performance of such duty, function or activity.

"(2) INDEMNIFICATION BY SECRETARY.— The Secretary shall make payment to an agency or organization under contract with the Secretary pursuant to this section, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such agency or organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any civil suit, action or proceeding brought against such agency or organization or person related to the performance of any duty, function or activity under such contract, provided due care was exercised by such agency or organization or person in the performance of such duty, function, or activity.".

(2) LIABILITY OF CARRIERS FOR FUNCTIONS PERFORMED UNDER SECTION 1842.—

(A) LIABILITY TO THE UNITED STATES.— Section 1842(e) (42 U.S.C. 1395u(e)) is amended—

(i) in paragraph (1) by inserting ", recklessness, or knowledge," after "gross negligence";

(ii) in paragraph (2) by inserting ", recklessness, or knowledge,"

after "gross negligence";

(iii) in paragraph (3) by striking all that follows "(3)" and inserting "A carrier shall be liable to the United States for a payment referred to in paragraph (1) or (2) if, in connection with such payment, an individual referred to in such paragraph acted with gross negligence, recklessness, or knowledge, or with intent to defraud the United States."; and

(iv) in paragraph (2) by striking "a voucher signed by" and inserting "an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of" after "based upon".

(B) LIABILITY TO THIRD PARTIES.— Section 1842 (42 U.S.C. 1395u) is amended by inserting at the end the following:

"(u) LIMITATION ON CIVIL LIABILITY.—

"(1) IN GENERAL.—No carrier having a contract with the Secretary under this section, and no person employed by, or having a fiduciary relationship with, any such carrier or who furnishes professional services to such carrier, shall by reason of the performance of any duty, function or activity required or authorized pursuant to this section or to a valid contract entered into under this section, be held to be civilly liable under any law of the United States or of any State (or political subdivision thereof), unless such carrier or person failed to exercise due care in the performance of such duty, function or activity.

"(2) INDEMNIFICATION BY SECRETARY.— The Secretary shall make

payment to a carrier under contract with the Secretary pursuant to this section, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such carrier, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any civil suit, action or proceeding brought against such carrier or person related to the performance of any duty, function, or activity under such contract, provided due care was exercised by such carrier or person in the performance of such duty, function, or activity.".

(g) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—

(1) CONTRACTS WITH FISCAL INTERMEDIARIES.—Section 1816(g) (42 U.S.C. 1395h(g)) is repealed.

(2) CONTRACTS WITH CARRIERS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking paragraph (5).

(h) SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS.—

(1) FISCAL INTERMEDIARIES.—Section 1816 (42 U.S.C. 1395h) is amended—

(A) in subsection (b), in the matter preceding paragraph (1), by striking "or renew"; and

(B) in subsection (c)—

(i) in the last sentence of paragraph (1), by striking "or renewing"; and

(ii) by adding at the end the following:

"(4)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

"(B)(i) The Secretary may renew a contract with a fiscal intermediary under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

"(ii) Functions may be transferred among fiscal intermediaries without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.".

(2) CARRIERS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended—

(A) by striking the text preceding paragraph (2) and inserting the following:

"(b)(1)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

"(B)(i) The Secretary may renew a contract with a carrier under subsection (a) from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the carrier has met or exceeded the performance requirements established in the current contract.

"(ii) Functions may be transferred among carriers without regard to any provision of law

requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers."; and

(B) in the last sentence of paragraph (2)(A), by striking "or renewing".

(i) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—Contracts under section 1816(a) (42 U.S.C. 1395h(a)) or 1842(a) (42 U.S.C. 1395u(a)) whose periods begin before or during the one year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this section may be entered into without regard to any provision of law requiring competition.

(j) AMENDMENTS TO CONFORM CONTRACTING TERMINOLOGY TO THAT USED IN THE FEDERAL ACQUISITION REGULATION.—

(1) CONTRACTS WITH FISCAL INTERMEDIARIES.—Section 1816 (42 U.S.C. 1395h) is amended—

(A) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking "an agreement" and inserting "a contract"; and

(ii) in paragraphs (1)(B) and (2)(A), by striking "agreement" each place it occurs and inserting "contract";

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the first sentence, by striking "An agreement" and inserting "A contract"; and

(II) in the last sentence, by striking "an agreement" and

inserting "a contract";

(ii) in paragraph (2)(A), in the matter preceding clause (i), by striking "agreement" and inserting "contract"; and

(iii) in paragraph (3)(A), by striking "agreement" and inserting "contract";

(C) in subsection (h)—

(i) by striking "An agreement" and inserting "A contract"; and

(ii) by striking "the agreement" each place it occurs and inserting "the contract";

(D) in subsection (i), by striking "an agreement" and inserting "a contract";

(E) in subsection (j), by striking "An agreement" and inserting "A contract";

(F) in subsection (k), by striking "An agreement" and inserting "A contract"; and

(G) in subsection (l), by striking "an agreement" and inserting "a contract".

(2) CONTRACTS WITH CARRIERS.—Section 1842(h) (42 U.S.C. 1395u(h)) is amended in paragraphs (2) and (3)(A) by striking "an agreement" and inserting "a contract".

(k) EFFECTIVE DATES.—

(1) The amendments made by subsections (a), (b), (d)(1)(C), (e), (f)(1)(B), and (f)(2)(B) apply to contracts whose periods begin after the third calendar month that begins after the date of enactment of this section.

(2) The amendments made by subsection (g) apply to contracts whose periods end at, or after, the end of the third calendar month that begins after the date of enactment of this section.

(3) Sections 1816(c)(4)(A) and 1842(b)(1)(A) of the Social Security Act, as enacted by subsection (h), apply to contracts whose periods begin after the end of the one year period specified in subsection (i).

(4) Sections 1816(c)(4)(B) and 1842(b)(1)(B) of the Social Security Act, as enacted by subsection (h), apply to contracts whose periods begin during or after the end of the one year period specified in subsection (i).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 14 2001

The Honorable Nancy L. Johnson
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Chairman Johnson:

Thank you for you letter of proposed administrative reforms to the Health Care Financing Administration, now renamed the Centers for Medicare and Medicaid Services (CMS), and the Medicare program. Please be assured that one of my immediate goals is to streamline CMS's administrative system.

We have reviewed your proposals, and have responded in detail to most of the issues you raised. A number of your questions related to regulatory reform, and we have refrained from addressing some of those here, since they are part of the reform effort initiated by the Secretary last Friday. I will follow-up with you shortly with detailed responses to those issues as well once I have had a chance to review our ideas with the new Task Force. We do have defined ideas to speed the regulatory process, and we will get back to you with results quickly.

Please do not hesitate to call if you have any additional questions. An identical letter is being sent to Congressman Stark.

Sincerely,

Thomas A. Scully

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 14 2001

The Honorable Pete Stark
United States House of Representatives
Washington, DC 20515

Dear Mr. Stark:

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We have reviewed your proposals, and have responded in detail to most of the issues you raised. A number of your questions related to regulatory reform, and we have refrained from addressing some of those here, since they are part of the reform effort initiated by the Secretary last Friday. I will follow-up with you shortly with detailed responses to those issues as well once I have had a chance to review our ideas with the new Task Force. We do have defined ideas to speed the regulatory process, and we will get back to you with results quickly.

Please do not hesitate to call if you have any additional questions. An identical letter is being sent to Chairman Johnson.

Sincerely,

Thomas A. Scully

Enclosure

Administrative Changes to Medicare

I. HCFA/CMS Management

A. Accountability in the HCFA/CMS Structure

Proposals:

1. A direct point of accountability within CMS should be established for oversight of regional office activities. This individual should be charged explicitly with reviewing regional activities to identify inconsistencies that may need policy attention.

   CMS Response

   We are reorganizing the agency around three centers to clearly reflect our major lines of business.

   - Center for Beneficiary Choices, which focuses on the Medicare+Choice program and providing beneficiaries with information upon which to base a choice. This includes management of the Medicare+Choice plans, consumer research and demonstrations, beneficiary education and grievance and appeals functions.
   - Center for Medicare Management that focuses on management of the traditional fee-for-service Medicare program. This includes development of payment policy and management of the Medicare fee-for-service contractors.
   - Center for Medicaid and State Operations which focuses on programs administered by States. This includes Medicaid, SCHIP, insurance regulation functions, survey and certification and CLIA.

   In addition, Rubin King-Shaw, the new Deputy Administrator, will act as CMS's Chief Operating Officer (COO). As the COO, he will have direct responsibility for our Regional Offices as well as other operational issues.

2. A dual entry accounting system should be a top priority with a specific deadline for completion and implementation.

   CMS Response

   As you know, Secretary Thompson has made this a top priority, one of CMS's greatest financial management challenges continues to be the lack of a dual entry financial management system that fully integrates CMS's accounting systems with those of our Medicare contractors. Therefore, a major component of our CFO comprehensive plan is to purchase a state-of-the-art, integrated accounting system, which will include our Medicare contractors' activities. This project is the CMS Integrated General Ledger Accounting System (HIGLAS). HIGLAS represents a major information technology investment to standardize the collection, recording, and reporting of Medicare financial information in order to enhance the management, accounting, and oversight of our programs. This project is well underway. On January 31, 2001, we issued a request for quotation and demonstration that will result in the procurement and implementation of a commercial-off-the-shelf accounting system. We will select a vendor by September 30, 2001. Our

implementation plan includes pilots at two Medicare contractors that will start operational implementation in July 2002 and be fully operational by January 2003. Our goal is to have HIGLAS fully implemented at all Medicare contractors by 2007.

B. A Systematic Regulatory Process

Proposals:

1. System of formal consultation with congressional committees of jurisdiction to ascertain whether regulations are consistent with legislative intent prior to release of notices of proposed rulemaking, consistent with the Administrative Procedures Act.

   CMS Response

   The agency will improve its communication with Congress in a number of areas. A regular schedule of meetings is being established with the three committees of jurisdiction – House Ways and Means, House Energy and Commerce and Senate Finance – to provide information on activities that the agency is undertaking such as rulemaking and other program guidance.

2. System of formal consultation with beneficiaries, provider groups, and other interested parties to solicit their input and guidance prior to release of notices of proposed rulemaking, consistent with the Administrative Procedures Act.

   CMS Response

   The agency will improve its communication with beneficiaries, provider groups, and other interested parties.

C. Expanding Outreach for Provider Education

Proposals:

1a. CMS contractors should offer technical experts to visit providers and work with them to evaluate systems to determine compliance and to suggest more efficient or more effective means of fulfilling program obligations.

1b. Working with various provider associations, CMS should develop an agreed upon system of information dissemination and training.

1c. Carriers, intermediaries and contractors shall conduct outreach to providers with fewer than 25 employees to implement education programs tailored to their needs.

CMS Response

CMS is instituting an aggressive education program designed to support physicians and other providers in caring for our Medicare beneficiaries. The Medicare program and clinicians share a common goal – high quality medical care for patients. As a consequence, we are concerned when we hear that aspects of the Medicare program are burdensome and interfere with that care. Medicare requirements need not only to be communicated well, but also to be sensible and supportive of physicians and other providers in caring for patients. Some of our current and planned activities include:

- The *Practicing Physicians Advisory Council* (PPAC), an advisory committee to the Secretary of HHS, is a valuable resource for information regarding the impact of our policy on practicing physicians. We will be redoubling our effort to improve the opportunity for input that this council provides.
- We are sending our staff out into the field to observe and better understand the day-to-day experience of practicing physicians. In September, we plan a similar event in a rural setting, in partnership with the Nebraska Medical Association and National Rural Health Association.
- We have doubled the number of physicians at the agency, have increased the number of other clinicians, and will aggressively recruit more physicians and clinicians. The objective is to ensure that the clinical perspective is considered in policy development.
- We are working with the professional associations that represent physicians and other providers, creating improved avenues for regular and consistent input. We will develop physician and provider focus groups, expand Regional Office outreach activities, and create other mechanisms to listen and communicate.
- This month, CMS is field-testing a new physician information resource web site to provide a more physician-friendly environment for one-stop shopping for Medicare information of interest to physicians. And, as soon as that site is placed on the web, we will move to organize similar sites for other Medicare providers.
- We will begin a modernization program that gives the Medicare contractor customer service representatives who handle physician/provider inquiries state-of-the-art desktop tools to enable improved responsiveness in handling telephone inquiries and combine this technology upgrade with the development of standardized resource materials and training for those customer service staff.

2. On-going technical assistance should include a convenient process of consultation to allow providers to seek help regarding a claim prior to its submission. All government or contractor employees should provide callers with either their name or other unique identifier to promote accountability.

   CMS Response

   We agree that providers should have access to information and assistance throughout the Medicare billing process, including assistance prior to claim submission. We are launching a pilot online resource to allow physicians to examine their medical and surgical procedure coding and reimbursement prior to claim submission. This will be a web-based physician education module that demonstrates Medicare Part B pricing and payment rules, including Correct Coding Initiative (CCI) edits, and illustrative local medical review policies. This training module is designed to be an educational tool that providers can use to take pre-emptive steps to identify payment errors in a "real time" interactive mode.

3. Full review and explanation of findings of audits should be made available to providers by CMS and its auditors to make sure providers understand the findings. Providers should also be informed of their appeal rights.

   CMS Response

On August 7, 2000, the Office of Financial Management issued Medical Review Progressive Corrective Action instructions to all fiscal intermediaries and carriers providing further guidance, underlying principles and approaches to be used in deciding how to deploy resources and tools for medical review. This program memorandum (PM) instructs contractors that provider feedback and education are essential to solving billing problems and contractors are increasingly incorporating this approach into their medical review procedures. This PM requires contractors to send written notification letters to all providers when they are placed on provider-service specific medical review and removed from medical review.

The notification letters must include at least the following information: (1) the reasons for medical review; (2) previous review findings; (3) planned medical review; (4) potential for continuation of or increase in medical review levels; (5) description of the specific actions the provider must take to resolve the problems identified in the medical review process; (6) an offer to provide individualized education; and (7) the name and telephone number of a contact person who is familiar with the contents of the notification letter.

We believe that the overwhelming majority of providers, suppliers and physicians who provide services to Medicare beneficiaries are honest, careful and conscientious. We do however, recognize honest billing mistakes do happen and have taken steps to ensure providers are made aware of their mistakes and know how to correct them.

4. Frequently asked provider questions and CMS's answers to those questions should be made publicly available to all providers over the internet. We understand this request is currently being implemented by the agency, and we encourage you to make sure the internet site is easily accessible.

   CMS Response

   Over the past year, CMS has made it a practice to make available a list of web-based frequently asked questions (FAQs) for major Medicare program initiatives. These FAQs are publicly available to all providers over the Internet. For example, for the recent implementation of the Hospital Outpatient Prospective Payment system, responses to over 250 questions are available. Similarly, for the Home Health Prospective Payment system, approximately 40 responses to questions are available. We have also established electronic listserves on priority initiatives that has enabled us to keep thousands of subscribers informed about the latest Medicare changes. We expect to continue these practices for future significant initiatives, as well as investigate the feasibility of developing a new system to capture, compile, and index frequently asked questions for all providers.

D. Medicare Contractor Oversight

Proposals:

1. CMS should investigate and examine adopting the relevant standards from the best private industry practices for improving their processes for procurement and supervision of contractors.

   CMS Response

   We agree and we are currently investigating best practices for performance management.

2. CMS should identify any legislative or regulatory barriers that exist in their ability to adopt these processes and work with the Congress to resolve any roadblocks.

CMS Response
The President's proposal for reform of the Medicare contractors adopts best industry practices for improving the management of the Medicare contractors. We would gradually reduce the number of contractors. Work would be awarded competitively using performance based contracts that include appropriate incentives. This would allow us to maximize economies of scale and improve the level of service to beneficiaries and providers.

Highlights of the contractor reform proposals include:

- Restructuring the right of hospitals and some other providers to nominate the contractor who will process their claims;
- Restructuring the requirement that carriers be health insurers to maximize competition among qualified entities;
- Restructuring the contractors' right to terminate their contracts and to contest CMS termination decisions in hearings before the DHHS Secretary;
- Allowing CMS (consistent with the Federal Acquisition Regulation) to negotiate the best type of contract for the work to be performed; and
- Requiring that CMS enter into contracts on a full-and-open basis, but provide flexibility to renew contracts without competition based adherence to specified performance requirements.

E. Release of Information
Proposal:

1. CMS should establish processes to release detailed information and the assumptions underlying the rates used to reimburse providers. The process should ensure that the privacy of beneficiaries is clearly protected and there is industry consensus on the release of data. This is not intended to affect the release of facility specific data on quality.

CMS Response
CMS is sensitive to provider concerns about the development of rate-setting regulations and quality improvement and measurement. We currently make available public use data files and other information associated with our rate setting efforts, but we will investigate the possibility of releasing more detailed and specific data in these areas, including an analysis of how we can do this while protecting beneficiary and provider privacy in the data we release. We will also take a fresh look at how we describe our methodology in regulations preambles to determine if we can help address provider concerns through that venue.

II. Strengthening Fee-for-Service

A. Coverage of Self-Administered Drug and Biologicals
Proposal:

1. CMS should issue the necessary program memorandum as soon as possible.

CMS Response
BIPA made an important statutory change to preserve coverage of drugs and biologicals. We are carefully evaluating this change and look forward to implementing a new policy as expeditiously as possible.

B. Compendia of FDA-Approved Drugs and Biologicals
Proposal:
1. CMS should accept the USP-DI compendium, as the successor to the AMA's New Drugs compendium, thereby allowing new products listed in USP-DI to be reimbursed as long as they meet Medicare's other coverage requirements.

CMS Response
We agree. We will recognize drugs that are included in the USP-DI as meeting the definition of "drugs" or "biologicals" under Section 1861(t)(1). We expect to issue a clarification shortly on this issue.

C. Certification of Diabetes Self-Management Programs
Proposal:
1. CMS should grandfather the state-level certifications currently in place in 10 states as valid for purposes of Medicare reimbursement. All new programs would still be subject to the ADA standard.

CMS Response
Section 1865 of the Social Security Act authorizes CMS to deem national accreditation organizations to ensure that Medicare requirements are met. We have no authority under the statute to deem State level organizations. Therefore we are not able to grandfather the State-accredited programs currently in place in 10 States. We notified the Congressional Diabetes Caucus of this statutory problem last year, and we provided technical assistance to fix the problem (in the form of statutory language) to Representative Nethercutt (the Caucus' co-chair), at his request. We would be happy to work with Congress on such a legislative fix that would allow State-accredited programs to be recognized, while at the same time assuring that the statutory quality requirements are met.

D. Simplifying Patient Assessment Instruments and Process
Proposals:
1a. Home Health Agencies – CMS should convene a Technical Experts Panel (TEP) of agency representatives, clinicians, and patient advocates to simplify the use of the Outcome and Assessment Information Set (OASIS) form and limit the time and number of individuals that are evaluated. The TEP should consider the effect of the length of the interview on the patient and avoid repetition without cause.

1b. Skilled Nursing Facilities – CMS should convene a TEP of agency representatives, clinicians, patient advocates, and the states to revise and simplify the MDS.

1c. The longer-term evaluation required in BIPA of the MDS should include the development and testing of new as well as existing measures.

CMS Response
One of CMS's earliest priorities is to undertake a thorough review of the assessment instruments that are currently in use in our programs and an evaluation of the extent to which the volume of items included in the instrument and the frequency with which it must be completed are truly required to meet the need to operate payment systems and perform quality improvement efforts. CMS will convene TEPs to examine and simplify both OASIS and the MDS.

E. Standardization of Local Medical Review Policies (LMRPs)
Proposals:

1. CMS should require the intermediaries and carriers to move to a single set of LMRPs for each state and for each metropolitan area that overlaps several states. This rationalization and simplification should be a high priority for the agency.

CMS Response
CMS agrees that inconsistencies between carrier and intermediary local medical review policies may lead to uneven coverage of Medicare services and is reviewing the most efficient and appropriate means of standardizing these local policies. However, because intermediaries process claims from as many as 48 different states, the logistics and technical requirements needed to establish a consistent local medical review policy within a state are challenging.

2. CMS should direct intermediaries and carriers to exclude emergency services that meet the prudent layperson standard from the LMRP policies.

CMS Response

- CMS has recently met with the AMA and the American College of Emergency Physicians (ACEP) to discuss their concerns with the Advanced Beneficiary Notice (ABN) requirements for billing patients for non-covered services and the EMTALA requirements which prohibit asking the patient for payment information before the patient is screened and stabilized.

- CMS has explained that for Medicare patients that come to a hospital emergency department with a medical condition, Medicare requires and will pay the hospital to screen the Medicare patient for an emergency medical condition and stabilize the patient if necessary. Medicare will pay for medically necessary tests or treatments required to screen and stabilize the Medicare patient. Once the stabilization is underway, the hospital may then request the patient to sign an ABN, which would allow the hospital to bill the patient for services determined under a LMRP to be non-covered.

- CMS asked both the AMA and ACEP to submit specific situations where a carrier has denied payment for screening and stabilization for an emergency medical condition based on an LMRP. However, to date no specific cases have been brought to our

attention.

F. Simplifying Cost Reporting

Proposals:

1a. For hospitals, CMS should create a TEP to develop a new cost report for FY 2003. The review should be directed at determining what data can be eliminated or simplified, given the current reimbursement methodologies. All stakeholders including CMS, OIG, fiscal intermediaries, providers and data users should be involved in the review process.

1b. For providers paid under cost-based reimbursement for only a few services or items, CMS should not make any changes to the cost reporting manuals, unless it results in a reduction in administrative expense for providers or is directed towards improper payment problems.

1c. CMS should not expend resources to audit the cost reports of facilities, where audit changes would not directly affect reimbursement.

1d. Electronically submitted cost reports from software that has been approved by CMS should not be rejected because of errors in the electronic edits and affect the deadline for timely submissions. Instead, there should be alternative processes to resolve issues.

1e. For free-standing SNFs, CMS and the providers should evaluate the feasibility through a TEP of reducing the cost report to include only the financial data that show assets, liabilities and owners' equity, known as the trial balance, balance information and a few key Medicare statistics such as the patient census and bad debt. Data available by other sources, for example, Medicare days by resource utilization group (RUG) should not be part of the cost report, without a compelling reason to include such data.

1f. For home health agencies, CMS and the interested stakeholders should reevaluate through a TEP the length and complexity of the form and consistency of information provided in home health cost reporting.

CMS Response

We agree that cost report reform, beginning with reform in the hospital cost report, is a key component of administrative reform. We already meet frequently with industry groups to discuss such matters and have had an internal CMS group discussing cost report reform for more than a year. We also participated in a study funded by the Assistant Secretary for Planning and Evaluation with respect to hospital cost reports.

The acute care hospital cost report is ripe for reform; however, there remain a number of legislative requirements (mostly associated with OPPS) that require calculation derived from the cost report (these requirements sunset in January 2004). Other cost-reimbursed hospitals continue to be paid on the basis of reasonable costs and subject to TEFRA limits until prospective payment systems are implemented for them. Critical Access Hospitals are by definition paid on a cost basis. Finally, many hospitals have long since integrated their cost report responsibilities into more complex administrative data systems, and these systems would need to be changed if the cost reporting requirements were changed. We will

actively consider the interests of all the stakeholders as we work to determine how best to accomplish cost report reform for hospitals so that the transition from the current set of requirements is smooth and appropriate.

We expect to work towards the simplification of cost reports for facilities other than acute care hospitals. For example, SNFs and HHAs have come under prospective payment systems and may well be able to be simplified, consistent with the need for cost data to evaluate and refine those systems. We believe that simplifications in this area are possible and will begin work immediately to look at potential changes.

At the same time we examine the structure and content of cost reports, we agree to reevaluate the process for auditing the cost reports. We will refine the process to focus only on those areas with the highest vulnerability and risk to program benefits.

G. The Expansion of Emergency Medical Treatment and Active Labor Act (EMTALA)
Proposals:

1a. CMS should reexamine how EMTALA applies to individuals presenting to non-emergency care sites on the hospital main campus, reviewing the role of non-emergency staff.

1b. The expansion of EMTALA to non-hospital property beyond the main campus should be revised to a standard of close proximity. Moreover, emergency personnel would not be expected to leave the premises unless an emergency situation was observed or brought to their attention.

CMS Response

CMS understands that hospitals view the current regulations as burdensome. We intend to revisit the existing regulations to determine whether changes are needed. In any clarifications or revisions, we will need to consider minimizing the burden on hospitals within the context of the statutory intent that patients with an emergency be stabilized or appropriately transferred by the hospital, regardless of the patient's ability to pay for those services.

H. Advanced Beneficiary Notice (ABN) for Home Health Services
Proposals:

1a. CMS should develop a demand bill process that is faster and does not trigger a RAP until the decision to pay is made. State Medicaid agencies should not require agencies to inappropriately submit a demand bill for patients that do not meet the coverage requirement under the "homebound" definition.

1b. CMS should reevaluate the frequency that home health providers must give ABNs.

CMS Response

CMS is working to deal with both the issues raised here. On the ABN front, we recently issued a series of questions and answers (and made them available on our web sites) relating to the timing and content of ABNs that dealt with a wide range of the concerns that providers had raised. We have also made improvements in the design of the ABN form so

that it can be printed on one page and have tested the new form with beneficiary focus groups. We hope to get early OMB approval to use it.

We are also working to resolve the billing difficulties that may arise in third party liability situations, primarily when Medicare and Medicaid are payers for the same beneficiary. We have been working with representatives of States and the HHA industry to identify procedural solutions. We will continue to address these issues until we develop appropriate solutions to the "demand bill" problem and implement them.

I. **Ambulance Billing**

Proposals:

1a. CMS should develop a consistent nationwide process and coding for demand bills for ambulance services.

1b. CMS should report back to Congress by June 15th their evaluation of condition codes, diagnosis codes and other methods for use in billing for ambulance services.

CMS Response

Last fall, we published a proposed rule for the ambulance fee schedule. This rule was largely based on the recommendations from the Negotiated Rulemaking Committee that included representatives from all of the interested parties. We received over 340 comments on the proposed rule and are developing the final rule. We look forward to working with ambulance companies to implement the fee schedule as well as to resolve other important issues, such as their need to improve the process of submitting demand bills.

J. **Medicare Secondary Payor (MSP)**

Proposals:

1. CMS should simplify Medicare secondary payor reporting to eliminate collection of know data (other than needed identifiers) and minimize the burdens on providers while maximizing CMS's ability to comply with the law.

CMS Response

- CMS frequently meets with a group of hospitals on this issue.
- As a result of these meetings, CMS has developed some proposed policies and procedures which would grant some relief to hospitals with respect to the gathering and reporting of MSP information, while at the same time complying with the law by continuing to provide protection for the Medicare trust funds.
- We are now including the policies and procedures in a package for OMB to review in connection with the Paperwork Reduction Act.

2. Providers that do not have face to face contact with the patients should not be required to collect the MSP data.

CMS Response

- This type of situation arises where physicians send samples for testing to hospital reference laboratories, which in turn must bill Medicare and collect the correct MSP information from the patient. The hospital never sees the patient.

- At the meetings referred to above, this issue was discussed frequently.

- CMS staff are continuing to discuss this issue to see if there is a way to meet the providers' objections, while at the same time ensuring that bills are sent to the correct payer for payment.

K. Hospital Contracting in the Provider-Based Regulation

Proposal:

1. CMS should reexamine management contracts as a criterion for determining the provider-based status of on-campus services and departments.

CMS Response

CMS is aware of a number of issues that must be resolved in the context of the existing rules for determining provider based status, including the rules for services provided under a management contract. We intend to re-examine those rules and determine whether changes are needed.

L. The Medicare Summary Notice (MSN)

Proposal:

1. CMS should simplify and clarify the MSN during the next cycle of system revisions (by October 1, 2001).

CMS Response

We agree that the information on the Medicare Summary Notice (MSN) about hospital outpatient services is confusing and we are working to correct the information on the MSN. We are also educating the beneficiaries and providers about this issue.

- As of October 2001, all MSNs will begin to have "Medicare paid provider" information.

- The Outpatient PPS booklet "Your Guide to Outpatient Prospective Payment System" currently contains limited information on the MSN. CMS plans to revise this booklet for reprint in January 2002 in response to feedback about confusion on co-payments, coinsurance and other aspects of Outpatient PPS. We will expand and/or revise the MSN section at that time.

M. Medigap Premium Safe Harbor

Proposal:

1. The Inspector General should broaden a proposed safe harbor to allow all dialysis facilities to subsidize the Medigap premiums for indigent ESRD patients.

CMS Response

The Department is currently engaged in the final stage of rulemaking with regard to this

issue and we will take your views into account. While CMS does not speak for the Inspector General, there are a number of factors to balance in considering any broadening of the proposed safe harbor for dialysis facilities to subsidize Medigap premiums for their patients. On the one hand, given that many beneficiaries with ESRD are low-income, expanding assistance through the private sector would be desirable. On the other hand, there already is a program for assisting beneficiaries with ESRD with the cost of their Medigap premiums through the American Kidney Foundation. Also, to the extent that Medigap premiums are paid directly by dialysis facilities, the ability of beneficiaries to exercise their choice based on the quality data that we have recently begun making available through medicare.gov is diminished.

N. Improving Access to New Technology

Proposals:

1a. CMS should develop a public process for adopting new HCPC codes, including consideration of a quarterly addition of new HCPC codes.

1b. CMS should establish an open and timely coverage process for new laboratory tests. Consistent with the intent of the BBA, the LMRPs should be more national in scope and supported by a process that allows for comments from clinicians outside of government.

CMS Response

- We have taken a number of steps to improve our coding systems. Over the past five months we have met with organizations representing hospitals, physicians, clinical laboratories, and device manufacturers to obtain their input on how to improve our coding systems.

- We recently published a proposal as part of the inpatient hospital prospective payment system (PPS) proposed rule to accelerate the process of obtaining and using codes for new technology and services used during an inpatient hospital stay. BIPA requires that CMS develop procedures to allow public consultation in making coding determinations relating to new DME and clinical diagnostic laboratory codes. We are actively developing the procedures we will use for this purpose. In fact, we plan to test one part of that process by holding a public meeting in early August to request input from clinical and industry experts on prospective new laboratory codes that may be approved by the American Medical Association for 2002. We will specifically ask for input on how to determine the appropriate payment for these new tests. BIPA further requires that we establish the procedures within a year after enactment and we expect to meet that date. The issue of more frequent national HCPCS updates is also under review. However, there are administrative feasibility and provider impact issues that need to be carefully reviewed before we would consider changes.

- We support making more evidence-based national coverage policies for clinical laboratory tests. As required under the BBA, we engaged in negotiated rulemaking for 23 specific clinical laboratory tests. As a result of the negotiated rulemaking process we published a proposed rule. We received numerous comments from clinicians and others and expect to publish the final rule shortly. In addition, policies for other clinical

laboratory tests can be developed through our national coverage process as delineated in the April 27, 1999 Federal Register Notice and is also available on the Internet at http://www.hcfa.gov/coverage/8a1.htm. The national coverage process is an open and timely evidence-based coverage process that allows for clinical input from interested parties.

III. Medicare+Choice

A. Improving Oversight of Medicare+Choice

Proposals:

1. Regulatory authority for Medicare+Choice should be consolidated into a single office of Managed Care. The office should be located in the Washington, D.C. area instead of Baltimore.

   CMS Response

   As mentioned in the Secretary's announcement, all CMS activities related to private health plan choices for Medicare beneficiaries will be consolidated into a new Center for Beneficiary Choices. This new center will encompass all aspects of the Medicare+Choice Program (M+C), including program policy and operations, beneficiary education, and quality improvement activities.

2. Current law requires plans to provide information on advance directives to all enrollees. Current CMS rules also require plans to track decisions made by patients about whether they have an advance directive, to notify the enrollee's primary care provider (PCP) of the advance directive and if it changes or is cancelled. Since such decisions are primarily private matters between patients and physicians, the current requirement for plans to track advanced directives should be discontinued.

   CMS Response

   CMS is committed to reducing administrative burden for M+C organizations. Although this particular issue has not been raised in previous discussions with the industry, we will examine this requirement and any administrative burden associated with this requirement.

3. Allow on-line enrollment application for beneficiaries with appropriate protection for beneficiary privacy.

   CMS Response

   CMS is exploring different ways to take advantage of on-line capabilities to improve the efficiency of M+C enrollment. Specifically, M+C plans can now submit waiver requests that propose alternative ways to process enrollment for beneficiaries enrolling via an employer or union group. We are in the process of reviewing waiver requests, some of which include on-line enrollment. The evaluation criteria for such requests will include the presence of sufficient protection for beneficiary privacy. Once approved, we will monitor and consider new procedures for further pilot testing and/or national implementation of on-

line enrollment.

B. Risk-Adjustment Mechanism for Medicare+Choice

Proposal:

1. HHS should continue to develop a risk adjuster that better reflects the cost of providing care to beneficiaries and is based on the most accurate data possible.

   CMS Response

   As indicated in the Secretary's May 25th letter to the three industry associations, CMS has suspended the required filing of physician and hospital outpatient encounter data through July 1, 2002. In the interim, the Department will work closely with all interested parties to explore and implement a risk adjustment process for M+C payments that balances accuracy and administrative burden. In a subsequent June 6th letter to Congresswoman Nancy Johnson and Congressman Pete Stark, CMS Administrator Thomas Scully reiterated the Administration's commitment to the implementation of an improved risk adjustment methodology. CMS intends to explore the use of alternative data collection methods that will be less burdensome to the managed care industry. In the event that a satisfactory alternative is not available, CMS will resume collection of physician and hospital outpatient encounter data in July 2002.

C. Plan Information – Improving the Decision-Making Process

Proposals:

1. A consistent process should be developed with improved turn around times. HHS should allow uniform marketing package related to standard benefits to be used nationally.

   CMS Response

   CMS is currently working to improve the turn-around times for review of marketing materials. With respect to the use of marketing materials nationally, CMS has established a review process for national "chain" organizations whose operations span more than one CMS region. This applies to all marketing materials, in addition to those describing plan benefits. CMS is working with each of these national organizations to develop a review process that addresses their specific needs.

2. Once marketing materials are approved, they should be valid for the entire plan contract (annual). Subsequent changes in plan benefits should be sent as a separate notice to beneficiaries.

   CMS Response

   Under CMS's current marketing review guidelines, approved marketing materials are valid for the entire plan contract year; any changes in plan benefits may be sent as a separate notice to beneficiaries throughout the year.

3. HHS should examine standard form letters for different categories of beneficiary notices.

CMS Response

Each fall, CMS conducts an extensive campaign to educate Medicare beneficiaries about their health care options, with particular focus on M+C choices. In the fall of 2001, we plan to implement a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. This will include:

- expanding phone service availability at 1-800-MEDICARE to 24 hours a day, 7 days a week;
- developing a web-based "Decision Tool" to help consumers compare their health plan choices (M+C plans, Medicare Fee-for-Service, and Medigap plans);
- enabling customer service representatives at 1-800-MEDICARE to provide more in-depth help to callers on finding the health plan choice that is best for them; and
- conducting a publicity campaign on the new choices and new ways to get information.

4. HHS should re-evaluate the review process for beneficiary documents – especially the 45-day rule – to determine where the process can be streamlined.

CMS Response

CMS is currently re-evaluating the marketing review process, especially the 45-day rule, to determine where the process can be streamlined and has already taken the following steps towards reducing the length of review time:

- CMS currently develops model marketing materials where possible to reduce the amount of time required for review. These model materials helped to streamline the review process under CMS's implementation of the Beneficiary Improvement and Protections Act (BIPA) earlier this year, when CMS had approximately two weeks to review marketing materials.

- In addition, BIPA established a 10-day review period for M+COs that use model materials without modification. CMS will adhere to this 10-day review period for materials that follow (without modification) model materials describing their 2002 benefits, specifically the Annual Notice of Change (ANOC) and the Summary of Benefits (SB).

- CMS will allow M+COs to release their ANOC and SB prior to approval of their Adjusted Community Rate Proposal (ACRP), provided that these materials include the disclaimer, "pending Federal approval." In previous years, CMS did not allow release of these materials until the ACRP had been approved.

- CMS will also suspend the final verification requirement for the ANOC and SB for 2002; rather than submitting a "camera ready copy" to CMS for review prior to printing and dissemination, the M+CO need only send a copy to CMS after the materials have been mailed to beneficiaries.

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the ability of the Health Care Financing Administration (HCFA), to carry out its mission to manage the Medicare program now and in the future. Although HCFA was renamed last week to become the Centers for Medicare and Medicaid Services (CMS), our statement will continue to refer to HFCA where our findings apply to the organizational structure and operations associated with that name. Because of Medicare's vast size and complex structure, in 1990 we designated it as a high-risk program that is, at risk of considerable losses to waste, fraud, abuse, and mismanagement and it remains so today. Since that time, we have consistently reported on HCFA's efforts to safeguard Medicare payments and streamline operations.

With congressional attention on proposals by Members and others to reform or modernize Medicare, the program's management by HCFA has become a prime concern. Proposals for Medicare reform recommend altering HCFA's governance structure, making improvements to existing operations, or some combination of both. They are being made against a backdrop of growing expectations for how the nation's largest health insurance program should be managed.

Therefore, my remarks today will focus on (1) HCFA's record of performance in managing Medicare and (2) gaps that exist between the agency's success in operating the program and the expectations held by HCFA's stakeholder community to make the program more modern and efficient. My comments are based on previous and ongoing work by us and published reports by others.

In brief, as the nation's largest insurer, HCFA is closely watched by a vast universe of stakeholders. The agency has had some notable successes as Medicare's steward, but has also had serious shortcomings. HCFA has been successful in developing payment methods that have helped to contain Medicare cost growth and paying its fee-for-service claims quickly and at low administrative cost. However, HCFA's oversight of claims administration has not been sufficient to ensure that claims contractors operated effectively and that claims were paid properly, and its oversight of nursing homes and other providers did not adequately ensure care quality. Further, HCFA has been unable to rely on its outdated computer systems to produce reliable management information. Without this information, HCFA has had difficulty effectively managing the program, including being able to measure the impact of recent payment method changes and developing needed refinements.

HCFA has taken significant steps to address weak areas, but its ability to improve its performance is constrained by multiple factors. HCFA's ability to manage has been diminished by frequent turnover in leadership, a relatively sparse cadre of senior executives, human capital challenges that threaten to worsen in the near future, the lack of a performance-based approach to management, constraints on its contracting authority that limit its flexibility to choose claims administration contractors and assign administrative tasks, and archaic information technology systems incapable of providing critical, timely management information. The desire to strengthen Medicare management argues for increased capacity, better documentation of the agency's resource needs, and means to hold managers accountable for results.

BACKGROUND

The complexity of the environment in which HCFA operates the Medicare program cannot be overstated. It is an agency within the Department of Health and Human Services (HHS) but has responsibilities over expenditures that are larger than those of most other federal departments. Medicare alone ranks second only to Social Security in federal expenditures for a single program. Medicare spending totaled over $220 billion in fiscal year 2001; covers about 40 million beneficiaries; enrolls and pays claims from nearly 1 million providers and health plans; and has contractors that annually process about 900 million claims.

Among Medicare's numerous and wide-ranging activities, HCFA must monitor the roughly 50 claims administration contractors that pay claims and set local medical coverage policies;[1] set tens of thousands of payment rates for Medicare-covered services from different providers, including physicians, hospitals, outpatient and nursing facilities, home health agencies, and medical equipment suppliers; and administer consumer information and beneficiary protection activities for the traditional pro-

[1] 1Most medical policies for determining whether services are reasonable, are necessary, and should be covered are set locally by the insurance companies that Medicare contracts with for fee-for-service claims administration.

gram component, the managed care program component (Medicare+Choice plans), and Medicare supplemental insurance policies (Medigap).

The providers billing Medicare create, with program beneficiaries, a vast universe of stakeholders hospitals, general and specialty physicians, and other providers of health care services whose interests vary widely. HCFA's responsibility to run the program in a fiscally prudent way has made the agency a lightening rod for those discontented with program policies. In particular, HCFA's administrative pricing of services has often been contentious. However, when Medicare is the dominant payer for services or products, HCFA cannot rely on market prices to determine appropriate payment amounts because Medicare's share of payments distorts the market. Moreover, because Medicare is prevented from excluding some providers to do business with others that offer better prices,[2] it is largely impractical for HCFA to rely on competition to determine prices.

Medicare's public sector status also means that any changes require public input. Thus, HCFA is constrained from acting swiftly to reprice services and supplies even when prevailing market rates suggest that payments should be modified. The solicitation of public comment is a necessary part of the federal regulatory process to ensure transparency in decision-making. However, the trade-off to seeking and responding to public interests is that it is generally a time-consuming process and can thwart efficient program management. For example, in the late 1990s, HCFA averaged nearly 2 years between its publication of proposed and final rules.[3]

Consensus is widespread among health policy experts regarding the growing and unrelenting nature of HCFA's work. The Balanced Budget Act of 1997 (BBA) alone has had a substantial impact on HCFA's workload, requiring, among other things, that the agency develop new payment methods for different post-acute-care and ambulatory services within a short time frame and It also required HCFA to preside over an expanded managed care component that entailed coordinating a never-before-run information campaign for millions of beneficiaries across the nation and developing means to adjust plan payments based partially on enrollees' health status.

HCFA HAS MIXED RECORD OF SUCCESS

Tasked with administering this highly complex program, HCFA earns mixed reviews in managing Medicare. On one hand, HCFA presides over a program that is very popular with beneficiaries and the general public. It has implemented payment methods that have helped constrain program cost growth and has paid claims quickly at little administrative cost. On the other hand, HCFA has difficulty making needed refinements to payment methods. It has also fallen short in its efforts to ensure accurate claims payments, oversee its Medicare claims administration contractors, and ensure the quality of Medicare services. In recent years, HCFA has taken steps to achieve greater success in these areas. However, the agency now faces criticism for imposing payment safeguards that many providers feel constitute an undue administrative burden.

HCFA's New Payment Methods Have Helped Contain Cost Growth

HCFA has been successful in developing payment methods that have helped to contain Medicare cost growth. Generally, over the last 2 decades, Congress has required HCFA to move Medicare away from reimbursing providers based on their costs for every service provided and use payment methods that seek to control spending by rewarding provider efficiency and discouraging excessive service use. Some efforts have been more successful than others, and making needed refinements to payment methods remains a challenge. For example, Medicare's hospital inpatient prospective payment system (PPS), developed in the 1980s, is a method that pays providers fixed, predetermined amounts that vary according to patient need. This PPS succeeded in slowing the growth of Medicare's inpatient hospital expenditures. Medicare's fee schedule for physicians, phased in during the 1990s, redistributed payments for services based on the relative resources used by physicians to provide different types of care and has been adopted by many private insurers.

More recently, as required by the BBA, HCFA has worked to develop separate prospective payment methods for post-acute care services services provided by skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities as well as for hospital outpatient departments. Prospective payment systems can help to constrain the overall growth of Medicare payments. But as new payments systems affect provider revenues, HCFA often receives criticism about the ap-

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[2] Statutory constraints on excluding providers from participating in Medicare have resulted in the program traditionally including all qualified providers who want to participate.

[3] This finding reflects the last half of 1997 and the first half of 1998 and an average of 631 days.

propriateness and fairness of its payment rates. HCFA has had mixed success in marshalling the evidence to assess the validity of these criticisms and to make appropriate refinements to these payment methods to ensure that Medicare is paying appropriately and adequately.

Medicare Processes Claims Inexpensively, But Greater Scrutiny and Control Needed

HCFA has also had success in paying most claims within mandated time frames and at little administrative cost to the taxpayer. Medicare contractors process over 90 percent of the claims electronically and pay "clean" claims[4] on average within 17 days after receipt. In contrast, commercial insurers generally take longer to pay provider claims.

Under its tight administrative budget, HCFA has kept processing costs to roughly $1 to $2 per claim—as compared to the $6 to $10 or more per claim for private insurers, or the $7.50 per claim paid by TRICARE—the Department of Defense's managed health care program.[5] Costs for processing Medicare claims, however, while significantly lower than other payers, are not a straightforward indicator of success. We and others have reported that HCFA's administrative budget is too low to adequately safeguard the program. Estimates by the HHS Inspector General of payments made in error amounted to $11 billion in fiscal year 2000, which, in effect, raises the net cost per claim considerably. Taken together, these findings suggest that an investment in HCFA's administrative functions is a trade-off that could ultimately save program dollars.

Moreover, due in part to HCFA's historically uneven oversight, the performance of some Medicare's claims administration contractors has been unsatisfactory. Among its failings, HCFA relied on unverified performance information provided by contractors and limited checking of each contractor's internal management controls. HCFA's performance reviews and treatment of problems identified were not done using consistent criteria across contractors. In the last year, HCFA has taken significant steps to improve its management and oversight of contractors. Nevertheless, key areas needing improvement remain, such as policies to verify contractor-reported data and controls over contractor accountability and financial management, including debt collection activities.

A major aspect of contractor performance—the stewardship activities that contractors conduct to safeguard Medicare dollars—is itself a story of mixed results. In the early 1990s, HCFA's contractors decreased certain key safeguard activities to maintain claims processing timeliness under constrained budgets. In order to ensure that program safeguards were strengthened, the Congress created the Medicare Integrity Program (MIP), which gave HCFA a stable source of funding for these activities as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In fiscal year 2000, HCFA used its MIP funding to support a wide range of anti-fraud-and-abuse efforts, including provider and managed care organization audits and targeted medical reviews of claims.

These audits and reviews, targeted at providers whose previous billings or cost reports have been questionable, have been a cost-effective approach in identifying overpayments. Based on HCFA's estimates, in fiscal year 2000, MIP saved the Medicare program more than $16 for each dollar spent. As part of its safeguard efforts, HCFA also has begun to measure how accurately its contractors process claims, to determine if individual contractors are effective in safeguarding program payments. Such objective information could provide HCFA with important management information and identify contractors' "best practices" that could serve as a model for others.

While HCFA has strengthened its payment safeguard activities, these efforts have raised concerns among providers about the clarity of billing rules and the efforts needed to be in compliance. Providers whose claims are in dispute have complained about the burden of reviews and audits and about the fairness of some specific steps the contractors follow. However, their concerns about fairness may also emanate from the actions of other health care overseers—such as the HHS Office of Inspector General and the Department of Justice—which, in the last several years, have become more aggressive in pursuing health care fraud and abuse.

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[4] These are claims that have been filled out properly and whose processing has not been stopped by any of the systems' computerized edits. According to HCFA data on claims processed in fiscal year 1999, about 81 percent of Medicare claims were processed and paid as clean claims.

[5] Much of the cost difference appears attributable to differences in program design and processing requirements, but we and others believe that TRICARE has opportunities to reduce this administrative cost. See *Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs* (GAO/T–HEHS–00–138, June 22, 2000).

HCFA faces a difficult task in finding an appropriate balance between ensuring that Medicare pays only for services allowed by law while making it as simple as possible for providers to treat Medicare beneficiaries and bill the program. While an intensive claims review is undoubtedly vexing for the provider involved, very few providers actually undergo them. In fiscal year 2000, HCFA's contractors conducted complex medical claims reviews of only three-tenths of 1 percent of physicians—1,891 out of a total of more than 600,000 physicians who billed Medicare that year.[6] We are currently reviewing several aspects of HCFA's auditing and review procedures for physician claims to assess how they might be improved to better serve the program and providers.

HCFA's Oversight of Health Care Quality Generally Has Been Weak

HCFA's oversight of health care quality, a resource-intensive activity, has significant shortcomings. The agency is responsible for overseeing compliance with federal quality standards for the services delivered to Medicare beneficiaries. As much of the actual inspection of quality is carried out by the states, HCFA must work with the states to ensure that the inspectors of nursing homes, home health agencies, renal dialysis centers, psychiatric hospitals, and certain Medicare-certified acute care hospitals identify significant care problems.[7] Our findings on nursing home quality present a very disturbing picture: in 1999, we reported that an unacceptably high number of the nation's 17,000 nursing homes—an estimated 15 percent—had recurring care problems that caused actual harm to residents or placed them at risk of death or serious injury. Our previous findings showed that complaints by residents, family members, or staff alleging harm to residents remained uninvestigated in some states for weeks or months. HCFA's efforts to oversee state monitoring of nursing home quality were limited in scope and effectiveness, owing, in part, to a lack of expert staff to assess the state inspectors' performance.

Even with this record of weak federal oversight, nursing homes get more scrutiny than other health care providers. States survey nursing homes at least yearly, on average, whereas other facilities are surveyed much less frequently. For example, home health agencies were once routinely reviewed annually, but surveys now vary and can be as infrequent as every 3 years. In addition, our work has shown that the number of HCFA-funded inspections of dialysis facilities declined significantly between 1993 and 1999, dropping the proportion reviewed from 52 percent to 11 percent. Yet, in 1999, 15 percent of the facilities surveyed had deficiencies severe enough, if uncorrected, to warrant terminating their participation in Medicare.

MAJOR GAPS EXIST BETWEEN HCFA'S CAPABILITIES AND STAKEHOLDER EXPECTATIONS

In addition to the challenges inherent in running Medicare, other factors associated with HCFA's structure and capacity diminish the agency's ability to administer the program effectively. These limitations leave HCFA poorly positioned to operate Medicare as a modern, efficient health care program.

Multiple Constraints Help Explain Agency's Mixed Record

HCFA faces several limitations in its efforts to manage Medicare effectively. These include divided management focus, little continuity of leadership, limited capacity, lack of a performance-based management approach, and insufficient flexibility to modernize program operations.

Agency Focus and Leadership

HCFA's management focus is divided across multiple programs and responsibilities. Despite Medicare's $220-billion price tag and far-reaching public policy significance, there is no official whose sole responsibility it is to run the Medicare program. In addition to Medicare, the HCFA Administrator and senior management are responsible for oversight of Medicaid and the State Children's Health Insurance Program. They also are responsible for individual and group insurance plans' compliance with HIPAA standards in states that have not adopted conforming legislation. Finally, they must oversee compliance with federal quality standards for hospitals, nursing homes, home health agencies, and managed care plans that participate in Medicare and Medicaid, as well as all of the nation's clinical laboratories. The Administrator is involved in the major decisions relating to all of these activi-

[6] Complex medical reviews are in-depth reviews of claims by clinically trained staff based on examination of medical records. In contrast, routine medical reviews may be carried out by nonclinical staff and do not involve review of patient records.

[7] The Joint Commission on the Accreditation of Health Care Organizations oversees quality in about 80 percent of Medicare-certified acute care hospitals; the other Medicare-certified hospitals, nursing homes, renal dialysis centers, home health agencies, and laboratories have quality reviewed by state surveyors.

ties; therefore, time and attention that would otherwise be spent meeting the demands of the Medicare program are diverted.

A restructuring of the agency in July 1997 inadvertently furthered the diffusion of responsibility across organizational units. The intent of the reorganization was to better reflect a beneficiary-centered orientation throughout the agency by interspersing program activities across newly established centers. However, after the reorganization, many stakeholders claimed that they could no longer obtain consistent or timely information. In addition, HCFA's responsiveness was slowed by the requirement that approval was needed from several people across the agency before a decision was final.

The recent change from HCFA to CMS reflects more than a new name. It consolidates major program activities: the Center for Medicare Management will be responsible for the traditional fee-for-service program; the Center for Beneficiary Choices will administer Medicare's managed care program. We believe that this new structure could improve efforts to more efficiently manage aspects of Medicare.

At least two other factors weaken agency focus. First, the frequent turnover of the administrator has complicated the agency's implementation of long-term Medicare initiatives or pursuit of a consistent management strategy. The maximum term of a HCFA administrator is, as a practical matter, only as long as that of the President who appointed him or her. Historically, their actual tenure has been even shorter. In the 24 years since HCFA's inception, there have been 21 administrators or acting administrators, whose tenure has been, on average, about 1 year. Over 15 percent of the time, HCFA has had an acting administrator. These short tenures have not been conducive to carrying out strategic plans or innovations an administrator may have developed for administering Medicare efficiently and effectively.

Of equal concern is the sparseness of HCFA's senior ranks. Its corps of senior executives is smaller than that of most other civilian agencies having significantly smaller annual expenditures. In fiscal year 1999, HCFA had 49 senior executive officials to manage Medicare, Medicaid, and SCHIP (among other programmatic responsibilities) and nearly $400 billion in expenditures. While some tasks at HCFA are contracted out—thus providing HCFA with purchased executive expertise—contractors' objectives may not be fully aligned with those of the agency. Indeed, the critical need to oversee contractors effectively to ensure that they are fulfilling their responsibilities has been repeatedly demonstrated.

Agency Capacity

In addition to leadership constraints, the agency's capacity is limited relative to its multiple, complex responsibilities. Inadequate information systems and human capital hobble HCFA's ability to carry out the volume of claims administration, payment and pricing, and quality oversight activities demanded of the agency.

Ideally, program managers should be able to rely on their information systems to create a feedback loop that allows them to monitor performance, use the information to develop policies for improvement, and track the effects of newly implemented policies. In reality, most of the information technology HCFA relies on is too outdated to routinely produce such management information. Despite major advances in information technology in recent years, HCFA relies on outmoded systems, some of which date back to the 1970s, to pay claims and maintain data on beneficiaries' use of services. As a result, HCFA cannot easily query its information systems to obtain prompt answers to basic management questions. Using its current systems, HCFA is not in a position to report promptly to the Congress on the effects of new prospective payment policies on beneficiaries' access to services and on the adequacy of payments to providers. It cannot expeditiously determine the status of debt owed the program due to uncollected overpayments. It cannot obtain reliable data on beneficiaries enrolled in managed care plans and must reconcile one system's output with data from other systems. Finally, HCFA lacks a set of rules to govern how it will develop, implement, and operate systems to prevent and detect inappropriate access.

Staff shortages—in terms of skills and numbers—also beset HCFA. These shortages were brought into sharp focus as the agency struggled to handle the number and complexity of BBA requirements. When the BBA expanded the health plan options in which Medicare beneficiaries could enroll, HCFA's staff had little previous experience overseeing these diverse entities, such as preferred provider organizations, private fee-for-service plans, and medical savings accounts. Few staff had experience in dealing with the existing managed care option—health maintenance organizations. Half of HCFA's regional offices lacked managed care staff with clinical backgrounds—important in assessing the appropriateness of a health plan's denial of services to a beneficiary—and few managed care staff had training or experience

in data analysis key to monitoring internal trends in plan performance over time and assessing plan performance against local and national norms.[8]

Staffing constraints have also handicapped HCFA's efforts to ensure quality of care. In recent years, the agency has made negligible use of its most effective oversight technique for assessing state agencies' abilities to identify serious deficiencies in nursing homes—an independent survey performed by HCFA employees following the completion of a state survey. Conducting a sufficient number of these comparisons is important because of concerns that some state agencies may miss significant problems, but HCFA lacked sufficient staff and resources to perform enough of these checks. In 1999, the number of HCFA independent surveys averaged about two per state—a frequency totally inadequate to fairly measure any state's performance.

At the same time, HCFA faces the loss of a significant number of staff with valuable institutional knowledge. In February 2000, the HCFA Administrator testified that more than a third of the agency's current workforce was eligible to retire within the next 5 years and that HCFA was seeking to increase "its ability to hire the right skill mix for its mission." As we and others have reported, too great a mismatch between the agency's administrative capacity and its designated mandate could leave HCFA unprepared to handle Medicare's future population growth and medical technology advances.[9] To assess its needs systematically, HCFA is conducting a four-phase workforce planning process that includes identifying current and future expertise and skills needed to carry out the agency's mission and analyzing the gaps between them.[10] HCFA initiated this process using outside assistance to develop a comprehensive database documenting the agency's employee positions, skills, and functions.

Once its future workforce needs are identified, HCFA faces the challenge of attracting highly qualified employees with specialty skills. Due to the rapid rate of change in the health care system and HCFA's expanding mission, the agency's existing staff may not possess the needed expertise. While the Congress has granted exemptions from the Office of Personnel Management salary rules for information technology staff, these exemptions do not extend to other skills—such as clinical experience and managed care marketing expertise.

Strategic Management Approach Lacks Performance Component

While HCFA has many resource-related challenges—including rehabilitating its information systems—the agency has not documented its resource needs well. As early as January 1998, we reported that the agency lacked an approach—consistent with the Government Performance and Results Act of 1993 (GPRA)—to develop a strategic plan for its full range of program objectives. Since then, the agency has developed a plan, but it has not tied global objectives to management performance. Moreover, its workforce planning efforts remain incomplete.

To encourage a greater focus on results and improve federal management, the Congress enacted GPRA—a results-oriented framework that encourages improved decisionmaking, maximum performance, and strengthened accountability. Managing for results is fundamental to an agency's ability to set meaningful goals for performance, to measure performance against those goals, and to hold managers accountable for their results. Last month, we reported on the results of our survey of federal managers at 28 departments and agencies on strategic management issues.

The proportion of HCFA managers who reported having output, efficiency, customer service, quality, and outcome measures was significantly below that of other government managers for each of the performance measures. HCFA was the lowest-ranking agency for each measure—except for customer service, where it ranked second lowest. It should therefore be no surprise that HCFA managers' responses concerning the extent to which they were held accountable for results—42 percent—was significantly lower than the 63 percent reported by the rest of the government.

Agency Authority and Flexibility

Statutory constraints are another structural issue that at times frustrate HCFA's efforts to manage effectively. One such constraint involves HCFA's authority to contract for claims administration services. At Medicare's inception in the mid-1960s, the Congress provided for the government to use existing health insurers to process and pay physicians' claims and gave professional associations of hospitals and cer-

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[8] HHS Office of the Inspector General, *Medicare's Oversight of Managed Care: Implications for Regional Staffing,* (OEI–01–96–00191, April 1998).

[9] Gail Wilensky et al. and "Crisis Facing HCFA & Millions of Americans," Health Affairs, Vol. 18, No. 1 (Jan./Feb. 1999).

[10] 10HCFA's workforce planning efforts to date have been in line with our guidance on this subject, as articulated in Human Capital: A Self-Assessment Checklist for Agency Leaders (GAO/GGD–99–179, Sept. 1999).

tain other institutional providers the right to "nominate" their claims administration contractors on behalf of their members. At that time, the American Hospital Association nominated the national Blue Cross Association to serve as its intermediary.[11] Currently, the Association is one of Medicare's five intermediaries and serves as a prime contractor for member plans that process over 85 percent of all benefits paid by fiscal intermediaries. Under the prime contract, when one of the local Blue plans declines to renew its Medicare contract, the Association—rather than HCFA—chooses the replacement contractor. This process effectively limits HCFA's flexibility to choose the contractors it considers most effective.

HCFA has also considered itself constrained from contracting with non-health insurers for the various functions involved in claims administration because it did not have clear statutory authority to do so. As noted, the Congress gave HCFA specific authority to contract separately for payment safeguard activities, but for a number of years the agency has sought more general authority for "functional contracting," that is, using separate contractors to perform functions such as printing and mailing and answering beneficiary inquiries that might be handled more economically and efficiently under one or a few contracts. HCFA has been seeking other Medicare contracting reforms, such as giving the agency general authority to pay Medicare contractors on an other-than-cost basis, to provide incentives that would encourage better performance.[12]

Growing Expectations Underscore Need to Address HCFA Governance And Management Issues

Although the health care industry has grown and transformed significantly since HCFA's inception, the agency and Medicare, in particular, have not kept pace. Nevertheless, HCFA is expected to make Medicare a prudent purchaser of services using private sector techniques, improve its customer relations, and be prepared to implement benefit and financing reforms.

Private insurance has evolved over the last 40 years and now offers comprehensive policies and employs management techniques designed to improve the quality and efficiency of services purchased. Private insurers have taken steps to influence utilization and patterns of service delivery through efforts such as beneficiary education, preferred provider networks, and coordination of services. They are able to undertake these efforts because many have detailed data on service use across enrollees and providers, as well as wide latitude in how they run their businesses. In contrast, HCFA's outdated and inadequate information systems, statutory constraints, and the fundamental obligation to be publicly accountable have stymied efforts to incorporate private sector innovations. In a recent study, the National Academy for Social Insurance has concluded that these innovations could have potential value for Medicare but would need to be tested to determine their effects as well as how they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. In addition, HCFA would need enhanced capacity to broadly implement many of these innovations.

HCFA is also expected to improve its customer service to the provider community. In seeking answers from HCFA headquarters, regional offices, and claims administration contractors, providers contend that the agency does not speak with one voice, adding frustration to complexity. We are currently studying ways in which communication with providers—including explanations of Medicare rules—could be improved.

HCFA has also been expected to improve communications with beneficiaries, particularly as the information pertains to health plan options. As required by the BBA, HCFA began a new National Medicare Education Program. For 3 years the agency has worked to educate beneficiaries and improve their access to Medicare information by annually distributing a Medicare handbook containing comparative health plan information; establishing a telephone help line and an Internet web site with, among other things, comparative information on nursing homes, health plans, and Medigap policies; and sponsoring local education programs. Although funding for these activities previously came largely from user fees collected from Medicare+Choice plans, future funding is less certain.[13] At the same time, such out-

[11] Intermediaries primarily review and pay claims from hospitals and other institutional providers covered under Medicare part A, while carriers review and pay claims from physicians and other outpatient providers covered under part B.

[12] For a discussion of this issue, see Chapter 3 in Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS–99–115, July 14, 1999).

[13] The Balanced Budget Refinement Act of 1999 significantly reduced the amount of user fees HCFA can collect from Medicare+Choice plans in 2001 and subsequent years.

reach efforts are becoming increasingly important, because in 2002 beneficiaries' options for switching health plans will be more limited than they are today.

The future is likely to hold new challenges for CMS. For example, the agency may be expected to oversee a prescription drug benefit administered by third parties. As we reported to this Committee last year, the administration of a drug benefit would entail numerous challenges, as the strategies now used by the private sector are not readily adaptable to Medicare because of its public sector obligations. Those challenges notwithstanding, the capacity issue remains. The number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services, or about 900 million annually.

Today's processing and scrutiny of drug claims by pharmacy benefit managers (PBM) is very different from Medicare's handling of claims for other services. PBMs have the ability to provide on-line, real-time drug utilization reviews. These serve a quality- and cost-control function by supplying information to pharmacists regarding such things as whether a drug is appropriate for a person based on his or her age, medical condition, and other medications, as well as whether the drug is covered under the insurer's benefit and what copayments will apply.

If the use of PBMs or other entities were an option in administering a Medicare prescription drug benefit, it is not clear how much they or the others would have to increase current capacity or instead use more of the capacity already built into their information and claims processing systems a consideration that could significantly affect the administrative costs that may be incurred. To administer this benefit through such contracts would require the agency to increase its managerial ranks with the personnel qualified to oversee such an operation. This would include staff with pharmaceutical industry expertise who could structure performance contracts in line with program goals for beneficiary access and fiscal prudence.

To meet these and other expectations will require an agency with adequate capacity to manage the Medicare program. The agency will need sufficient flexibility to act prudently, while being held accountable for its results-based decisions and their implementation. It will also need to devote management attention to the fundamentals of day-to-day operations.

CONCLUDING OBSERVATIONS

Medicare is a popular program that millions of Americans depend on for covering their essential health needs. However, the management of the program has fallen short of expectations because it has not always appropriately balanced or satisfied beneficiaries', providers', and taxpayers' needs. For example, stakeholders expect that Medicare will price services prudently; that providers will be treated fairly and paid accurately; and that beneficiaries will clearly understand their program options and will receive services that meet quality standards. In addition, there are expectations that the agency will be prepared to implement restructuring or added benefits in the context of Medicare reform. Today's Medicare agency, while successful in certain areas, may not be able to meet these expectations effectively without further congressional attention to its multiple missions, capacity, and flexibility. The agency will also need to do its part by implementing a performance-based approach that articulates priorities, documents resource needs, and holds managers accountable for accomplishing program goals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Committee Members may have.

RELATED GAO PRODUCTS

Medicare Reform: Modernization Requires Comprehensive Program View (GAO–01–862T, June 14, 2001).

Managing for Results: Federal Managers' Views on Key Management Issues Vary Widely Across Agencies (GAO–01–592, May 25, 2001).

Medicare: Opportunities and Challenges in Contracting for Program Safeguards (GAO–01–616, May 18, 2001).

Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance (GAO–01–506, Mar. 30, 2001).

Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform (GAO–01–539T, Mar. 22, 2001).

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO–01–247, Jan. 2001).

High Risk: An Update (GAO–01–263, Jan. 2001).

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives (GAO/HEHS–00–197, Sept. 28, 2000).

Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments (GAO/T–HEHS–00–160, July 19, 2000).
Medicare Payments: Use of Revised "Inherent Reasonableness" Process Generally Appropriate (GAO/HEHS–00–79, July 5, 2000).
Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure (GAO/T–HEHS–00–108, May 4, 2000).
Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight (GAO/HEHS–00–46, Mar. 23, 2000).
Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS–99–115, July 14, 1999).
HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century (GAO/T–HEHS–99–58, Feb. 11, 1999).
Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/THEHS–98–85, Jan. 29, 1998).

PREPARED STATEMENT OF NICHOLAS J. WOLTER

Chairman Baucus, Senator Grassley, and members of Senate Finance Committee, I appreciate this opportunity to discuss some of the challenges of working with the Health Care Financing Administration (HCFA), especially at a time when a change in name to the Centers for Medicare and Medicaid Services (CMS) is meant to reflect a commitment to improving working relationships with physicians, hospitals, nursing homes, other providers, and beneficiaries.

I am submitting these comments on behalf of Deaconess Billings Clinic. DBC is a not-for-profit, physician-led, community governed medical foundation serving Montana and northern Wyoming. It is composed of 170 physicians, located at 10 clinic sites, as well as a 272 bed hospital, a nursing home, and a research division. DBC also manages several small hospitals and nursing home facilities in towns with populations of less than 10,000.

DBC, like many other large health care organizations in rural states, serves a very large geographic region with primary, secondary and tertiary care services. It is common for patients to travel 90 minutes to Billings for a primary care visit, and five hours or more for a visit to one of our medical subspecialists. As part of a consortium of rural hospitals, DBC also operates a telemedicine network. DBC's mission is to improve the health of the communities we serve, and to support health care research and education.

I am Dr. Nick Wolter, the CEO of Deaconess Billings Clinic. I have spent most of my professional life practicing critical care medicine and pulmonology, and I still see patients today.

I'd like to start with several simple premises.

- Medicare should support the physician-patient relationship.
- Medicare should encourage quality, coordinated, and efficient care.
- Medicare regulations should be as simple and inexpensive to implement as possible.
- Medicare regulators should work in a cooperative, partnership manner with physicians and other providers.

Deaconess Billings Clinic believes that operating from these premises can provide Medicare beneficiaries, our patients, with the best care and the best value.

Over the past five years, a voluminous number of complex, often confusing regulations, combined with a major increase in compliance and enforcement initiatives, have left health care providers frustrated with Medicare's administration and straining for resources to comply.

One of our experienced directors recently expressed her concern with Medicare regulation and enforcement this way:

> "Something became extremely clear to me at the compliance conference we recently attended. HCFA and the OIG seem to make policy and take a shot gun approach to issues based upon isolated incidents of real problems in healthcare. I've worked for three large integrated systems at this point accounting for nearly 1,000 physicians. I've always been involved in the coding and billing aspects of healthcare, performing audits, appeals, ALJ hearings, etc. In the past 20 some odd years, I have only seen one physician (at another system) who was intentionally non-compliant with the rules of the day. All other issues with billing and coding were related to the fact that the regulations were very difficult to understand and operationalize and too numerous to reasonably keep track of. It seems to me we are adding complex and detailed rules and regulations, plus huge costs for implementation, in order to regulate a tiny minority of physicians and other providers. We're ruling on exception instead of the norm."

The main themes of this testimony are that Medicare regulatory simplification is needed. A more cooperative relationship between the new CMS and providers is needed. More consistency and coordination from the national level are needed, so that providers and beneficiaries in different regions receive more consistent service and policy implementation.

Let me describe some of what has driven DBC, and many other physician organizations, hospitals and other providers, to Congress, asking for regulatory relief and a change in HCFA.

BETTER GUIDANCE, MORE COORDINATION, AND MORE OVERSIGHT FROM THE NATIONAL LEVEL IS NEEDED

Documentation and Coding Guidelines

One of my pulmonology colleagues describes the documentation and coding problem by saying, "I spend as much time producing paper as I do taking care of patients." Medicare pays physicians based upon an incredibly complex set of coding guidelines, dating back to 1992, requiring documentation of services that often do not make sense to the physician in the room trying to take care of the patient. Efforts since 1993 to revise the guidelines have failed to meet the objectives of simplicity and of not interfering in the process of care.

Patients are often also confused. But they cannot tell where accountability rests. Is it with Medicare? Physicians and hospitals? Or is the problem a lack of partnership, coordination, and communication between Medicare and providers?

Example: Preventive Medicine Coding

Let me give you an example of a problem we are facing right now, especially in our internal medicine practices, with coding guidance on preventive medical exam, versus a problem medical exam. Medicare does not generally pay for a preventive exam, the patient does. So this is an area of great patient interest, where clarity is important. Furthermore, preventive exams are common. You would think that the guidance would be clear by now. What we find, however is the following:

- It is very difficult to determine, under current guidance, when a preventive medical exam becomes a problem exam.
- It is also very difficult to determine when a preventive exam becomes both a preventive exam and a problem exam, during the course of an exam. For instance, if the physician finds a potential heart problem or diabetes, when can billing be done for treatment beyond what would be done in the routine preventive exam? In this instance, we are faced with figuring out the correct billing procedure and making sure we do not charge the Medicare beneficiary for the part of the exam that should be billed to Medicare. This situation is extremely difficult to explain to the patient, even if we could get clear guidance from Medicare.
- Medicare now allows certain preventive tests for women (e.g. a screening pap smear, a breast exam and a pelvic) to be performed and billed to Medicare at the same time as a problem visit billed to Medicare. This is not the case in regards to screening for men. We may bill a preventive screening digital rectal exam to Medicare, but not at the same time as a problem visit billed to Medicare. This is difficult to understand and more difficult to explain to the patient.
- To make this issue even more confusing, we have been faced with differing interpretations from our Carrier and the Medical Director of our Carrier, as well as the Medicare Regional Office on these questions. There are no clear national guidelines in this area and this only perpetuates the confusion.

This month at DBC, we are bringing in a nationally recognized consultant in this area, at significant expense, to educate our physicians and staff on the best understanding we have of current requirements.

Another concern I hear about Evaluation and Management (E&M) Coding, especially from our subspecialists doing consults, is that it does not reward patient counseling. In order to get paid for a high level visit, for asthma or a heart condition, for instance, it isn't enough to thoroughly examine and counsel a patient on that condition, you are required to do a complete history and physical (which has often already been done by their primary care physician), and provide other services that may actually detract from counseling the patient on the condition he or she came to see you about. Effectively physicians face financial incentives to spend less time counseling patients in the areas the patient most needs counseling.

Local Medical Review Policies ("LMRPs"), "Medical Necessity" Determinations, and other Guidance (or lack thereof)

Medicare requires Medicare contractors to decide what is medically appropriate care, within the context of national guidelines. The number of LMRPs varies enor-

mously across the country by Medicare contractor, and the advice is often inconsistent. The effect is that beneficiary services vary from area to area because of the variations within Medicare administration. Quality may also be inconsistent. Medical evidence should drive Medicare's medical review policies, not variability in the opinions of local Medicare Medical Directors.

Nothing is more difficult for a practicing physician than to be told by the local Medicare Carrier or Fiscal Intermediary that the service he is providing or has authorized is not "medically necessary," especially when that payment denial decision is unsupported by medical evidence.

Example: Air Ambulance

Let me give you one recent, extremely serious example in Montana right now, involving air ambulance services. DBC, like several other hospitals in the state that provide trauma and higher level medical services, owns and staffs an air ambulance. The medical director of that service refers to it as a "flying ICU." We can and do save lives because of air transport. However, for the past several months, our local Medicare Fiscal Intermediary has been denying approximately half of our air transports on the grounds that they were not medically necessary. The denial is accomplished by downcoding to the payment rate for land ambulance. This is happening to other air ambulance programs across Montana, although we understand similar denials are not common with Medicare FIs in other states. Let me give you two examples of denials:

- A 78 year old female sustained a huge intracerebral hemorrhage and was transported by air for neurological evaluation. Vital signs were stable enroute and the patient was confused with slurred speech. Upon neurological evaluation, it was determined by the neurologist that the patient would likely not survive the event. The family made decisions for comfort care and the patient passed away 4 days later. This flight was denied by Medicare, stating that the patient was stable and could have been transported via ground ambulance. Due to the extent of her intracerebral hemorrhage, she could have compromised her airway at any time and did in fact lose consciousness shortly after arriving at DBC. We have appealed this denial.
- A 68 year old male presented to the Emergency Department of a small hospital with chest pain. The patient had an abnormal EKG and elevated cardiac enzymes indicating that he had suffered a heart attack. He was stabilized and transported by air for cardiac evaluation, and was not in active pain during the transport. The admitting cardiologist decided that due to the recent myocardial infarction, it was best to perform cardiac catheterization the following morning. The patient underwent cardiac catheterization within 18 hours of transport and underwent multiple vessel coronary artery bypass later in his hospital stay. This transport was denied based upon the fact that the patient was stable during the transport. The FI stated that the patient must experience chest pain during the transport to establish the medical necessity of air transport. We are appealing this denial based upon the fact that you can never predict which patients will be stabilized and which will continue to evolve and extend their myocardial infarction.

When a physician at DBC certifies an air transport, we believe we are following national guidelines, as well as practicing within the standard of care for a physician for determining when critical care is needed. Our local FI disagrees, requiring an "emergent" condition during transport, and using medical consequences after the time of transport to determine whether the transport was medically necessary. For heart patients, they have told us they look for heart pain during transport to justify medical necessity!

The problem with air ambulance is exacerbated in Montana by the vast distances involved and the absence of professional ambulance services in rural communities. In many communities in rural and frontier Montana, there is, at most, one ambulance, the ambulance is staffed by volunteers, and the ambulances do not provide advanced life support. Therefore, to do what our Medicare FI tells us we should be doing, which is transport the patient by land ambulance with advanced life support capacity, we must send an ambulance from Billings. If the patient is 250 miles from Billings, which is not uncommon, it would require a five hours trip to pick the patient up, then we'd be subjecting the patient to another five-hour trip back. As physicians and air ambulance providers, we cannot, in good conscience, with our patients' interest foremost, justify what our local FI has demanded as a matter of "medical necessity."

It is a terrible dilemma for DBC we are looking at losing approximately $500,000/year in Medicare denials in the future for our air ambulance program, based upon

current denial rates. We know other air transport programs in Montana are considering closing because of Medicare denials.

We believe this problem is due to a lack of coordination and national oversight of Medicare contractors. This leads to major inconsistencies from region to region and FI to FI. It is hard to understand, in cases where medical and expert consensus is available, why such major inconsistencies exist, particularly around issues where quality of care may be significantly compromised. In the case of air medical transport we understand that a national level review was done over a year ago, and that a proposal exists that would address our current problem. We believe more national oversight, expert medical involvement, and the development of consistent policies where medical agreement exists would help address this kind of situation. Even with this approach, much more timely decision-making is necessary.

Example: Ineffectiveness of Dispute Resolution related to disputes with Medicare contractors

Finally, our experience with air ambulance illustrates another problem with Medicare the ineffectiveness of dispute resolution. Under existing regulations, we have initiated appeals on the approximately 110 denials we received between November 1, 2000, and the end of April 2001. Because our Medicare fiscal intermediary has refused to change its position, we expect to be involved in lengthy and expensive administrative hearings on each claim. The Medicare regional office has not been helpful in trying to resolve the differences in approach between our fiscal intermediary and others in the region. And there is no mechanism that would allow resolution of this issue, as a matter of policy, at a national level.

Other problems with receiving adequate, timely, and consistent guidance from Medicare:

- Last fall, DBC implemented billing for blood products in a timely manner based upon national guidance. Our FI was unable to process the claims when appropriately billed according to national guidance, yet the Medicare clearinghouse through which DBC submits claims electronically (which is owned by our FI) would only accept the claims when submitted as required by the national guidance. We were stuck in a Catch-22, that required manual adjustments to every claim for blood products for several weeks. Our local FI informed us that we were not, in the future, to follow national guidance until it directed us to do so.
- The FI was unable to answer basic questions about billing as a "provider-based clinic," and seemed, from our viewpoint, unable to get adequate assistance from the regional or national level.
- The FI was unable to answer basic questions about implementing the outpatient prospective payment system, and, again, appeared not to receive adequate assistance and information from the regional or national level.

Medicare Rules often Micromanage Care and Direct Physicians How to Practice Medicine and Impose Onerous Paperwork Requirements

A few examples should suffice to demonstrate the problem with overly prescriptive regulations that interfere in the physician-patient relationship:

- Physician Supervision of Diagnostic Tests (Program Memorandum Transmittal B–01–28, issued April 19, 2001). This rule tells physicians, mainly radiologists, (1) when they must "generally supervise" a procedure, which means the procedure is furnished under the physician's direction and control, but their physician presence is not required, (2) when they must "directly supervise, which means they "must be present in the office suite and immediately available," but not in the room, or 3) when they must "personally supervise," which means they must be in the room during the performance of the procedure. The supervision requirement has meant that patients requiring contrasts for MRI must be done under direct supervision of a physician. As a result, patients requiring that procedure frequently must wait for the procedure, sometimes for hours, sometimes for days, raising quality of care concerns. We looked at 10 years of data, and could find no evidence of any safety concerns for patients related to use of contrasts that could not be handled by the highly trained RNs and other staff present, with supervision by radiologists via highly sophisticated technology, that effectively put the physician in the room.
- The recent outpatient prospective payment system rules tell physicians, based upon Medicare's notion of medical necessity, that some procedures will only be paid for by Medicare if done on an inpatient basis. The decision about what is the appropriate care for a specific patient is removed from physician judgment and the physician-patient relationship. Our radiologists can no longer do percutaneous drainage of an abdominal abscess on an outpatient basis, even if

the referring physician recommends it. Orthopedists can't decide that low back disk surgery, arm repair with a bone graft, or a single level laminectomy can be done on an outpatient basis, with proper pain management, as is frequently the case for non-Medicare patients.

- The Medicare Conditions of Participation require physicians to physically see an inpatient who is placed under restraints or seclusion within one-hour. This rule has posed a huge problem for our inpatient Psychiatric Center in terms of staffing and psychiatrist burn-out. While proper oversight of restraints and seclusion is important, this level of micromanagement is not.

We question the need for medical micromanagement of medical judgment through Medicare regulations and the Conditions of Participation. When it occurs, it should be based upon sound medical advice and evidence, not upon individual instances where additional safeguards were needed to prevent a bad outcome.

Examples of rules where we believe the burden to providers outweighs the reason for the rule include the following.

- Advanced Beneficiary Notices. The Medicare requirement to obtain Advanced Beneficiary Notices or ABNs is an extremely difficult operational task. The patient must be notified prior to receiving the service that Medicare does not consider this service medically necessary for his or her condition or will only pay for the service once within a prescribed time period. This requires a huge amount of education to our front line staff who must maintain large binders of all the possible limited coverage services and then must obtain a diagnosis from the doctor and search for the test or tests being ordered to determine if the diagnosis provided is on the list. Then in order to properly bill for this service our fiscal intermediary requires that you submit two bills—one with the covered services and another with the non-covered services. Splitting the bill in this manner is not easily accommodated in most healthcare billing software systems. This problem is made even more difficult when you serve as a reference laboratory and do not ever see the patient on your premises. Even though the lab only receives a specimen, it is still required to ensure that an ABN is acquired for certain tests. Physicians in their private offices experience this as an enormous burden when they are ordering lab tests.
- Medicare Secondary Payor Rules. The Medicare Secondary Payment rules, which received substantial attention during the last Congress, continue to be a significant problem. This rule requires providers to ask 25 questions of Medicare beneficiaries about other payment sources. Initially, this rule required that providers gather this information on every encounter. At DBC, patients will frequently have several encounters in a day. The paperwork burden to DBC and patients, alike, was huge, and actually interfered in the process of care. At this point, our FI requires that we collect such information every two months, which is too frequent. We understand that other FIs still require an MSP questionnaire be filled out on every encounter. More reform and more centralized guidance is needed.
- Medicare Cost Report Requirements. We would recommend eliminating the cost report for providers no longer paid on a cost basis, and would substitute the use of Generally Accepted Accounting Principles (GAAP) for financial reporting. At the very least, we believe reducing the size and complexity of the cost report is possible.
- Simplification of other Medicare data requirements. Medicare requires many disparate types of data, in addition to the cost report. Providers should not be required to keep or provide data unless the new CMS can show it is necessary to carry out its functions, is not otherwise available, and its usefulness is not outweighed by the resources required by providers to gather and provide the data.

Providers everywhere could tell you tales of woe, often involving complex manual processes, and inconvenience and costs to patients, because of these rules. We would like to see the new CMS reconsider the necessity for these rules, and to weigh their costs and the difficulty of implementation against the reason they were adopted. If they could not be completely eliminated, we believe they could be narrowed in scope.

The Volume and Combined Impact of the Rules is Overwhelming

The financial and human resource cost of responding to many of these regulations is becoming clearer to us at DBC and is huge. Staff salaries to support physician coding total $500,000 alone. In addition to trying on an ongoing basis to comply with the regulations discussed above, within the past year, other rules that touch every aspect of DBC operations have been adopted in the following areas:

- HIPAA: Based on expert outside consultation using a conservative approach DBC expects to spend 2.5 million dollars over the next few years complying

with Medicare HIPAA rules. We support the intent of many of these rules but hope that simplification of the requirements is yet possible, and that recognition of the practical and financial implications of implementation will be taken into consideration.

- Stark self-referral guidelines, which closely prescribe financial arrangements between physicians and entities: A technical violation of this law—for instance, failure to have a written contract for a fair market value transaction that otherwise poses no concerns—carries punitive penalties. For instance, if a DBC physician agrees to train staff on a new outpatient procedure that is going to be done at the facility, and is paid $100, under the Stark regulations, unless he has a written contract with that facility, both he and the facility have violated the law. As a result, the hospital would be precluded from billing Medicare for services that physician refers to that facility, and, if it provided services allowed procedures to be done on patients by that physician it would be required to return the money. This would be true even if all of the patients who got the procedures at the hospital needed them, and the physician and hospital were making a special effort to bring the procedures closer to home so people would not have to travel to the bigger hospitals. It is hard to know every time there is a relationship between a physician and an entity that may trigger the Stark rules. The cost of making certain a technical violation of Stark never occurs, for fear of the penalties, is large and unrecognized in Medicare's payments to providers.
- EMTALA: This law, enacted initially as an anti-dumping law at hospital Emergency Departments, is now, by way of HCFA's outpatient prospective payment rules as applied to provider based clinics, extended to every DBC outpatient physician office site in Billings, well beyond the actual property lines of hospitals. Furthermore, providers face a Catch-22 when payment for emergency care is denied by Medicare. We are precluded by EMTALA from asking questions related to the patient's ability to pay when the patient requests emergency services, but we are required to ask precisely those questions (and collect a written ABN from the patient) in order to bill the patient if Medicare denies payment for services provided during emergency treatment.
- Outpatient Prospective Payment System (OPPS): Initiated last August, DBC is still waiting for adequate guidance on some aspects of implementation of these rules. On some issues, like the "pass-through" payments and "inpatient-only" procedures, Medicare dramatically changed the rules, after the effective date, requiring an initial effort to comply, followed quickly by a second effort to comply with changes. The financial cost to DBC of implementing OPPS is now estimated at $750,000. Furthermore, we do not believe the changes related to OPPS were explained well, and on some issues not at all, to beneficiaries or to secondary payers.

The sheer volume, scope, detail, cost, and rapidity of regulatory changes, combined with substantial penalties for non-compliance, leave health care providers spinning.

Medicare Rules and Payment Inadequacies Create the Following Problems in Rural Areas

Rural physicians, hospitals, nursing homes, and home health agencies currently face enormous challenges. The most recent data collected in Montana for the year 2000 show small health care organizations in our state averaging an operating margin of a negative 6 to 7 percent.

As DBC has become more and more involved in the operation and management of both rural clinics and hospitals, it has become apparent to me that some of the geographic inequities in reimbursement to rural providers contribute to their fragile financial status. These geographic inequities include wage-price index formulas for facilities, a geographic adjustment of work RVUs for rural physicians, other geographic adjustments for both inpatient and outpatient facility services, and the Medicare payment rate for managed care in rural areas which preclude the offering of Medicare+ Choices options. These inequities extend to rural Medicare beneficiaries in at least two ways. First, resources to maintain and develop quality services are less available than in other parts of the country. Second, the beneficiaries themselves may find their own out-of-pocket expenses to be higher, which occurred when the new OPPS was implemented. In Montana significant increases in many hospital outpatient co-pays now exist. We even have co-pays which are higher than the charge itself. Surely increasing the burden on elderly patients in a state with a high senior population and a low per-capita income was not an intended result of the implementation of this complex new program. Let me also note that many Montana health care organizations have chosen to become Critical Access Hospitals, a program piloted in Montana, but severe vulnerability remains.

It is my strong belief that the regulatory and compliance initiatives launched by Congress and by HCFA over the past 5 years will only magnify the problems faced by Montana's rural and frontier physicians and hospitals. Many have negative margins now and do not, in most cases, have the resources to adequately invest in high-quality healthcare delivery infrastructure, much less the infrastructure required to deal with the regulatory and compliance issues we are discussing today. In many cases these physicians and hospitals represent the only access to basic healthcare services for 50, 100 or 200 miles and more. Many of these providers are seeking DBC's help in dealing with these issues, but all are asking why significant geographic disparities are so pervasive in Medicare's programs.

Let me give some specifics as to why these rural issues need urgent attention:

Physician Recruitment. Medicare does not cover the cost of providing physician services in rural areas. Because rural areas also have a disproportionately high Medicare population, the problem is exacerbated by lack of better paying patients to offset the Medicare losses.

Free-standing physician practices are dying because physicians can't make the equivalent of a market income, based on national standards, if they set up in private practice in a rural area. As a result, rural physicians are increasingly employed by hospitals that subsidize their salaries. Part of the reason for this is that Part B reimbursement to physicians in rural areas applies a geographic adjustment to the work component, so that Medicare pays rural physicians less than in other parts of the country. This is difficult for us to understand. In fact, DBC recruiters tell us that we should expect to take at least two years to recruit a primary care physician to small rural towns outside of Billings, and that we will often pay a 10% starting bonus premium. That has been our experience over the past few years. In Montana, if Part B payments for physicians were increased to the national average, it would result in approximately a 2.9% increase in payments. At that level, we would still be subsidizing the salaries of physicians in rural communities, but the burden would be lessened to DBC by approximately $500,000 a year.

Marginal to Negative Operating Margins. MedPAC has begun to identify some of the problems in reimbursement in rural areas. We believe recent MedPAC testimony on the report on rural health care may significantly understate the problem, but the increasing difference in margins between rural and urban hospitals is clear, and should be addressed.

Medical and Administrative Infrastructure. Health care today requires information systems and highly educated, professional staff in order to comply with the deluge of regulations and delivery quality care. There isn't enough money available to build the necessary infrastructure to deliver quality care to rural beneficiaries. Medicare reimbursement to rural hospitals has institutionalized historical, geographical inequities in the level of care provided in rural areas, effectively precluding improvement in the infrastructure. This problem will be magnified by the growing healthcare workforce shortage issues.

Quality and Access. There are very few subspecialists in rural Montana and Wyoming, except via telemedicine and outreach clinics. DBC provides both telemedicine and outreach clinics, and both are subsidized. While recruiting primary care providers is difficult in rural areas; cardiologists, dermatologists, ophthalmologists, gastroenterologists, and so on, don't exist in those areas. Patients, therefore, do not have access, except by virtue of extraordinary efforts, which are not recognized by Medicare payment methodologies. Right now, DBC and other trauma providers are struggling with building a regional trauma network, with no outside funding. Until Medicare addresses these kinds of problems, residents in rural areas will not have the quality of care or access to care that patients have in more urban areas where hospitals and physicians are paid more by Medicare for the same service.

"Patients or Paperwork?"

This is a question and dilemma posed by the American Hospital Association, on behalf of many of its members, including DBC. Physicians are asking the same question. The new Centers for Medicare and Medicaid Services needs to be asking, in a serious way, the same question, and to begin holding meaningful discussions with physicians, hospitals, and other providers about ways to create significant improvement. I encourage your attention to AHA's analysis and recommendations in this area.

Recommendations for Action

(1) Simplify coding and documentation standards. Pilot them with practicing physicians without threatened penalties for coding noncompliance.

(2) With practicing physician involvement, develop national payment policies, particularly in areas involving frequent services, certain chronic diseases, and critical-

care transport where evidence-based information exists to support more standardization. Replace many local medical review policies.

(3) Ensure that HCFA provides much improved communication, guidance, interpretation, and clarification to physicians, hospitals, and other providers as regulations are developed and implemented.

(4) Improve the supervision, support, and guidance provided to regional offices and FIs and Carriers to significantly reduce the variation and inconsistency in policy, service, and interpretation which exist today.

(5) Significantly improve, and make more timely, dispute resolution processes. The current ALJ process is unwieldy, expensive, and ineffective at resolving issues at a policy level.

(6) Consider the net effect of the timing and cost of regulatory implementation so that providers are able to balance their resources as they plan their own implementation needs.

(7) Eliminate or simplify rules that inappropriately regulate how physicians practice medicine, especially where there is little or no evidence to suggest that they improve quality or safety.

(8) Take into account the cost of implementing regulatory and compliance initiatives in reimbursement to physicians, hospitals, and other providers.

(9) Adopt the recommendations of the American Hospital Association in its "Patients or Paperwork?" project. Simplify, clarify, and make more practical specific current regulations including OPPS, EMTALA, Stark, data reporting mandates, cost reports, ABN's, Medicare secondary payor rules, and HIPAA.

(10) Address rural inequity issues which threaten facility viability, pay rural M.D.'s a lower work RVU, do not allow for adequate infrastructure investment, impair recruitment and retention of physicians, nurses, and other professionals, unfairly burden Medicare beneficiaries themselves, and do not allow the offering of program options to seniors available elsewhere.

(11) Improve communication, service and information to Medicare beneficiaries.

I want to thank Senator Baucus, Senator Grassley, and other committee members for the opportunity to share my observations on current issues facing physicians, hospitals, and other providers as we work with the newly named Centers for Medicare and Medicaid Services, our regional office, and our FI and Carrier to best serve our Medicare patients. Thanks to you all, as well, for your efforts to continually improve a program which has become vitally important to those it has served so well.

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